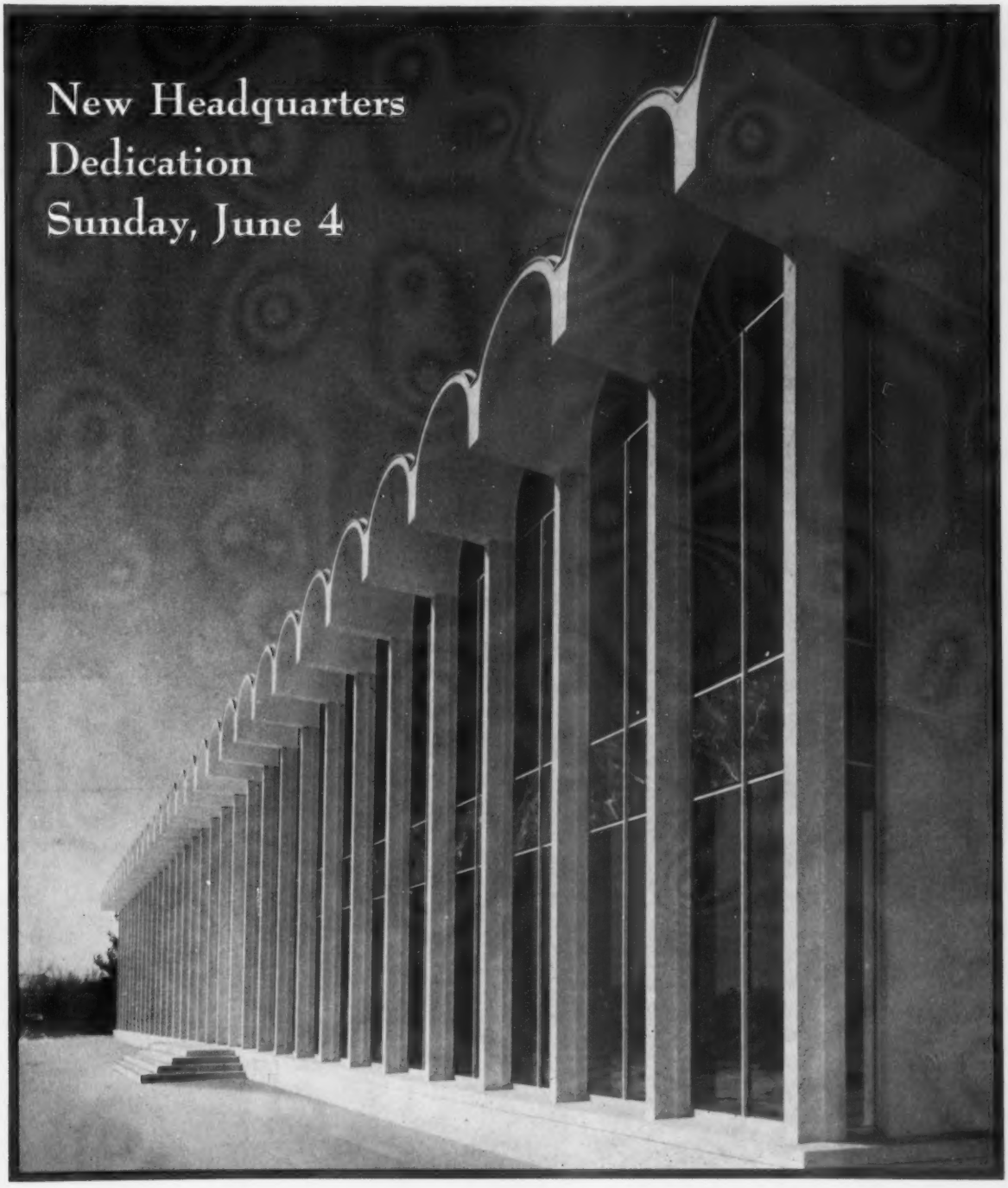
the Journal
MICHIGAN
STATE MEDICAL SOCIETY
MAY 1961 • VOLUME 60 • NUMBER 5



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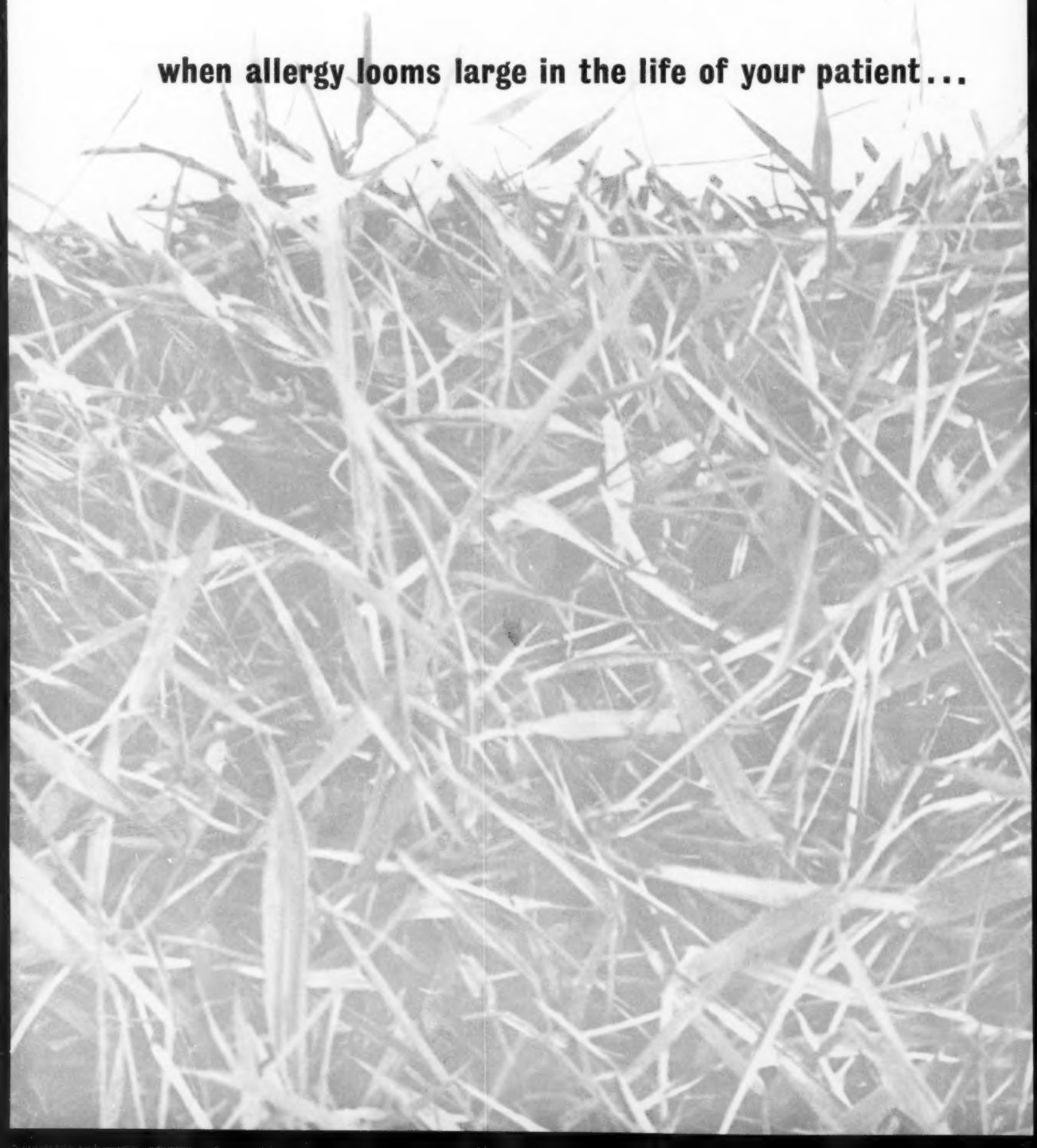

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the Journal MICHIGAN
STATE MEDICAL SOCIETY

Volume 60 Number 5

May, 1961

All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey, M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscriptions should be addressed to Wm. J. Burns, 606 Townsend Street, Lansing 15, Michigan. Telephone IVanhoe 2-1158.

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THE COVER

The new Michigan State Medical Society headquarters building in East Lansing will be dedicated Sunday, June 4. Every MSMS member and his lady are cordially invited to attend.

IN THIS ISSUE

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O. J. Johnson, M.D., Bay City	1961
C. I. Owen, M.D., Detroit	1961
Wm. Bromme, M.D., Detroit	1962
R. L. Novy, M.D., Detroit	1962
G. W. Slagle, M.D., Battle Creek	1962

Alternates

	Expires
W. W. Babcock, M.D., Detroit	1961
G. B. Saltonstall, M.D., Charlevoix	1961
J. M. Wellman, M.D., Lansing	1961
B. M. Harris, M.D., Ypsilanti	1961
L. R. Leader, M.D., Detroit	1962
J. R. Heidenreich, M.D., Daggett	1962
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President's Page

ADDED USEFUL YEARS

Kenneth N. Johnson

President
Michigan State Medical Society

"There are many facets of medical care, ranging from the ultimate in scientific aims such as solving the problems of a specific disease entity like 'rheumatic fever'—to pure economics such as bargaining between management and labor with medical care as one of the fringe benefits. This latter situation can be emphasized by repeating what was once stated to one of our committees while we were seeking a solution to some of these problems. A representative of management stated: 'No matter how worthwhile or good your program may be, I can only say that at the bargaining table it is decided on whether it costs a nickel more or a nickel less.'

"Between these two extremes occur a great variety of situations which require careful judgment to resolve. It is unfortunate when emotions interfere with such judgment, but it does happen occasionally. One of these situations is the business of living past age 65, a matter of increasing concern since more people live longer than used to be so.

"The Michigan State Medical Society has had a ten-point program for some time which we believe could best solve the problem of those over 65 years of age.

"MSMS also has a Presidents Program, an ambitious one, covering the next five years, in which we will take the lead but are counting strongly on help from a great number of different organizations to put over. This program is aimed at adding useful years to the lives of all citizens of this State.

"The AMA also has its ten-point plan of promoting the best health care possible for the citizens of this country. The AMA is studying every aspect of medical care costs and when finished will report to the public and the profession. It is dedicating its efforts to promote positive health objectives for older people with flexible retirement policies, home care programs and nursing homes designed for the elderly and others, and the AMA has many other activities.

"Physicians are proud of the fact that these programs are being initiated by, directed by and implemented to a great degree by the profession of medicine. There is nothing in their implementation which asks or puts the responsibility on government to run, although some of them ask government's cooperation. While we would be proud to have the help of any particular group, we feel this is our job and we should like to do it."

Excerpts from an address by President Johnson at the annual meeting of the Michigan League for Nursing, March 23.

New Headquarters Building Dedication, June 4

Eager for new opportunities to improve MSMS services to members and to the general public, the Michigan State Medical Society will dedicate its new headquarters building Sunday, June 4.

Every member of MSMS is cordially invited to participate in the afternoon ceremonies. The dedication program will provide the opportunity, too, for MSMS to explain new plans to expand and improve its operation.

Certainly, the MSMS Presidents Program is timely as it develops ways to "increase the potential productivity and usefulness of additional years of life."

To further quote Resolution No. 25 of the 1960 MSMS House of Delegates instituting the Presidents Program, it stated that "the facilities of the headquarters shall serve as the campaign 'control center' for the ambitious five-year plan." The conference rooms at the new headquarters, for example, will permit effective planning sessions with other groups and will ideally serve all MSMS committees with records and materials at their finger tips.

* * *

THE NEW MSMS headquarters is ideally suited for use by busy physicians. Situated at Highway M-78 and Abbott Road in East Lansing, the headquarters will be readily accessible from all points without hindrance from heavy city traffic. The new headquarters' parking area will accommodate 50 cars and can be expanded if needed.

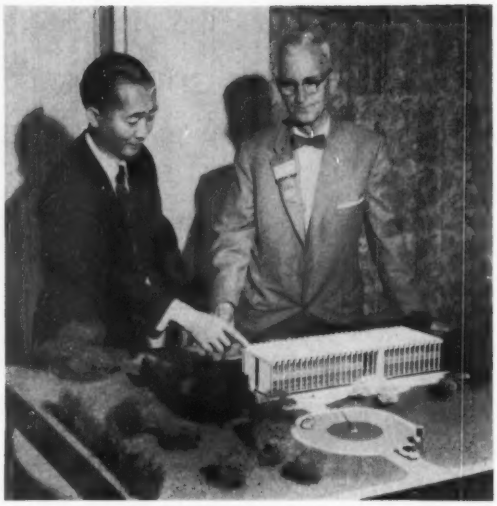
Fine residential areas surround the MSMS property, with Whitehills Estates immediately to the east and north. Since the purchase of this site, the Michigan Education Association has obtained nearby land on which it intends to construct a new office building in the near future. Another neighbor is the East Lansing Presbyterian Church.

As the doctor or other visitor enters the building, he will be greeted by a receptionist-telephone operator located in the center of a commodious lobby, two stories high. This area is the hub of the building and no office is more than 40 feet distant.

* * *

ON THE FIRST floor are located the offices of the MSMS President, business manager and bookkeeper, and an extra office for future growth. Also, in the western wing is located the stenographers' room and an all-purpose room which may be used for large committee meetings or educational gatherings.

The lower level contains workshops and storage rooms. For example, all mail will be processed there in a special room equipped with the latest devices to speed important correspondence to MSMS members. Here, also, will be rooms to store radio transcriptions, pamphlets, and the motion picture films from the PR Library, cleaning



A scaled model of the new headquarters was effective to help MSMS visualize the new building during the early stages of the Big Look Committee work. Architect Minoru Yamasaki explains a feature to William S. Jones, M.D., chairman of the Big Look Committee.

The groundbreaking ceremony was April 1, 1959 with members of The Council and guests participating. Turning the first shovel is G. B. Saltonstall, M.D., then President. Watching are Kenneth H. Johnson, M.D., left, then Speaker of the House, and D. Bruce Wiley, M.D., right, then Chairman of The Council.

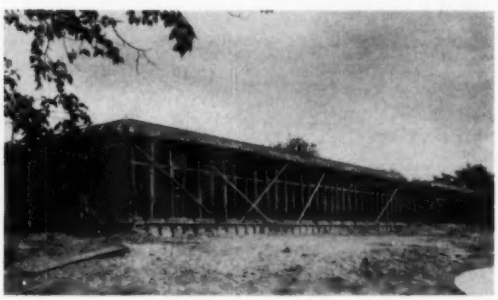
and repairing of films will be performed here also. In addition, recording equipment, tape recorder, and other audio-visual equipment will be set up in a specially designed room which subsequently can be used for motion picture production, radio and television broadcasting.

* * *

THE SECOND FLOOR will house the Directors Room, and a connecting smaller Committee Room which will provide ample space for even the largest MSMS committee meeting. Opposite this, the executive director and his assistant will be installed. The files of the Director's office thus will be at the immediate disposal of meetings in the Directors Room.

Down the hall is the Public Relations Library, crammed with research data, periodicals, surveys, 11

MSMS memorabilia was sealed into the cornerstone at the cornerstone-laying ceremony September 27, 1959 by G. B. Saltonstall, M.D., then President, assisted by Milton A. Darling, M.D., then president-elect, and A. E. Schiller, M.D., then chairman of The Council.



A progress photo of the headquarters before the pre-formed concrete columns and roof vaults were swung into place.

years of news clippings, reference works, audio-visual material for TV or speech presentations and education tape recordings. A part-time librarian will be on hand to efficiently operate this MSMS service to members. Other offices serve the public relations counsel, the assistant to the executive director and field secretaries.

* * *

THE ARCHITECT for the new headquarters building was Minoru Yamasaki, AIA, of the firm Minoru Yamasaki & Associates, of Birmingham.

The firm of Minoru Yamasaki & Associates has been cited by the American Institute of Architects and other organizations. Mr. Yamasaki was born in Seattle, Washington, and received his Bachelor of Architecture at University of Washington. His graduate work was taken at New York University, where he also served as instructor.

* * *

WM. S. JONES, Sr., M.D., chairman of the MSMS Big Look Committee, said, "On May 31, 1959, MSMS membership totaled 6,211—an increase of almost 2,000 members in eight years. The Townsend building has served us well, but we have outgrown it. The new headquarters has been planned with conservative foresight. We believe that our present and future needs are provided for and that the medical profession will have just cause for pride in its new and modern quarters."

Twenty-six years ago, the MSMS headquarters consisted of two small offices on the 20th floor in Lansing's tallest building, then known as Olds Tower. A staff of three, including the new Executive Secretary, Mr. William J. Burns, served the 3,410 members then listed in the MSMS roster.

"2020 Olds Tower" was the familiar address of MSMS for the next 16 years. During that time, the membership had grown to 4,667. Eight employes were handling the organizational and educational details of the association. In 1951, for reasons of economy and efficiency, MSMS left its downtown address and purchased a converted residence at 606 Townsend Street. In recent years, every available foot of floor space was filled with equipment, personnel and records. Not only has membership grown, but the demand for MSMS services has multiplied too.

The new headquarters building was designed to better serve the medical profession and the public. The structure symbolizes the dignity and high purpose of the medical profession. It was erected in tribute to the past and dedicated to the future.

On AMA Program

Advance programs issued for the American Medical Association's 110th annual meeting in New York City, June 25-30, lists a Michigan doctor on a panel discussion on "Renal and Adrenal Hypertension." The program combining General Surgery, Internal Medicine, Pathology and Physiology, Urology and General Practice, will offer a panel, including Marion S. DeWeese, M.D., Ann Arbor.

"606 Townsend" served MSMS well, from 1951 until "moving day" on April 24. Every available foot of space was being used in the remodeled residential building from the basement production rooms to the attic rooms for five staff members.

Another Michigan man is listed on early AMA plans. Talking about "Objective Measurement of the Effects of Drugs on Driving Behavior" will be James G. Miller, director, Mental Health Research Institute, University of Michigan.

Upper Peninsula Society Program Set June 16-17

An impressive program has been arranged for the 66th annual meeting of the Upper Peninsula Medical Society, June 16 and 17 at the Silver Dome Hotel-Motel at Marinette, Wisconsin.

The list of speakers will be headed by Kenneth H. Johnson, M.D., Lansing, president of the Michigan State Medical Society.

Others obtained for the event include William Kelly, M.D., Lansing; John Sheldon, M.D., and Harry Towsley, M.D., both of Ann Arbor; Ovid Meyer, M.D., Madison; Donald Moore, M.D., Bloomington; Merle M. Musselman, M.D., Lincoln, Nebraska; Oliver Rian, M.D., Peoria, Illinois, and H. W. Gintz, of the Medical Protective Company.

The Menominee County Medical Society will serve as host for the annual meeting.

Officers of the U. P. Society include John Heidenreich, M.D., Daggett, president; John R. Franck, M.D., Wakefield, president-elect, and George H. Hopson, M.D., Menominee, secretary-treasurer.

HIGHLIGHTS of The Council

Meeting of March 17, 1961

One-hundred and twenty items were presented to and discussed by The Council at its March 7 meeting in Detroit. Chief in importance were:

- Progress Report on new MSMS Headquarters Building. President Johnson stated the contractor would be out of the building the latter part of March which would permit the carpet people to begin work, following which, the furnishings would be installed. Goal for moving into the new building was set for April 25.

  Memorial contributions were increased by the offer of $500 from Mr. Lyle O. Wellman of Wellman Press, Lansing. Other donors, besides the Past Presidents and the Woman's Auxiliary, are Mrs. L. Fernald Foster, Detroit, $1,000; Dr. and Mrs. W. S. Jones, Menominee, $1,000; the Shook Family of Kalamazoo, $1,000; and Bruce Publishing Company of St. Paul, $1,000.
- Report from H. A. Towsley, M.D., Ann Arbor, on meeting of Council on Education and Hospitals, Chicago, February 4, was accepted with thanks and referred to the Editor for publication in JMSMS.
- D. L. Hinerman, M.D., Ann Arbor, Chairman of a committee for U-M Department of Postgraduate Medical Education engaged in a comprehensive review of postgraduate medical education, requested suggestions and recommendations from members of The Council for evaluation of past performance and the future needs of postgraduate medical education in Michigan. Doctor Hinerman was requested to send copies of the questionnaire to every member of The Council.
- Homer A. Stryker, M.D., Kalamazoo, was selected as Biddle Lecturer by President Kenneth H. Johnson, M.D.
- Support of Martin Fleming and Emily Sargent, both of Detroit, for reappointment by the Governor to the Michigan Crippled Children Commission was authorized.
- A proposed letter drafted by President Kenneth H. Johnson, M.D., for mailing to all MSMS members re the dangers and seriousness of the present situation in regard to attacks against medicine, was approved.
- M. H. Chapin, M.D., of Millington, requested permission to join Genesee County Medical Society because of proximity of Millington to Flint. The Council approved this request.

  Morton J. Wiener, M.D., of Ferndale, wishes to continue Wayne County Medical Society membership although his office is now in Oakland County on the border (WCMS membership committee has approved this request). The Council also gave approval.

  J. L. Tromp, M.D., of Lake Odessa, desires to transfer his membership from Ionia-Montcalm to the Barry County Medical Society because he is on the county border and has most of his affiliations in the Barry County area. The Council approved this request.
- Legal Counsel Lester P. Dodd presented five matters: (a) motion for a new trial has been made by Gonsertron of Bay City; (b) Mr. Dodd has prepared a brief on the advantages and disadvantages of incorporation of county medical societies; (c) information on Michigan's privileged communications statute and medical practice act was prepared and forwarded to Connecticut State Medical Society; (d) opinion re applicability of rules of evidence in proceedings before a county society ethics committee; (e) opinion (for MSMS Committee on Prevention of Highway Accidents) re legal implication of setting up county medical society advisory boards for medical re-evaluation of unfit driver.
- Public Relations Counsel reported on medical and health legislation, both federal and state; staffing of state fair exhibit; co-operation of MSMS with component societies wishing to extend awards to winners in local science fairs was approved; progress on study of single medical practice act was reported.
- 1961 Michigan Clinical Institute. Executive Director Burns reported on anticipated high registration at Discussion Conferences, a new feature of the 1961 MCI.
- Committee Reports. The following were given consideration: Child Welfare, meeting of December 8, 1960; Liaison Committee with Michigan Chapter of Health Insurance Council, January 25; Public Relations Committee, January 28; Committee to Survey Utilization of Health Insurance, February 1; Arrangements Committee for Residents-Interns-Senior Medical Students Conference, February 2; Advisory Committee to Executive Director, February 23; Medical Care Insurance Committee and RVS Study Committee, February 25-26; Geriatrics Committee, January 24. Other committee reports

(Continued on Page 564)

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Highlights of The Council

(Continued from Page 562)

presented were: Michigan Joint Council to Improve Health Care of the Aged, December 13; and Permanent Conference Committee, December 14.

- Michigan Medical Service. Matters of mutual interest and information were presented and discussed with Blue Shield President G. Thomas McKean, M.D., of Detroit, who introduced to The Council Mr. Sumner G. Whittier, Executive Vice President of Blue Shield.

  L. Gordon Goodrich of Blue Shield presented progress report on the Veterans Administration Hometown Medical Care Program, and also submitted contract for renewal of Medicare which was approved by The Council.
- Robert A. Reath, head of the Medical Television Unit of Smith, Kline and French Laboratories of Philadelphia, was introduced to The Council; Mr. Reath expressed his enthusiasm for the MCI television program and arrangements.
- Appointment of Committees. (a) Committee to Meet with Wayne County Medical Society Representatives to Resolve Question of MSMS Speakers appearing in Wayne County was appointed with R. W. Teed, M.D., Ann Arbor as Chairman; (b) Study Problem of Recruitment for Medical Careers: this matter was referred to the Subcommittee on Recruitment of the Public Relations Committee; (c) 1961 House of Delegates News Committee was appointed: J. J. Lightbody, M.D., Chairman, H. F. Falls, M.D., Ann Arbor, D. Bruce Wiley, M.D., Utica, and C. Allen Payne, M.D., Grand Rapids; (d) Scientific News Committee for 1961 Annual Session in Grand Rapids: H. G. Benjamin, M.D., Chairman, F. S. Alfenito, Jr., M.D., J. A. Ferguson, M.D., F. C. Brace, M.D., P. W. Kniskern, M.D., all of Grand Rapids, and A. B. Gwinn, M.D., of Hastings, and C. L. Weston, M.D., of Owosso.

  Committee on Scientific Exhibit for 1961 Annual Session is to be headed by J. R. Lentini, M.D., of Grand Rapids.
- MSMS Representatives to AMA Legislative Conference, March 18-19, Chicago: President Kenneth H. Johnson, M.D., Lansing, President Elect Otto K. Engelke, M.D., Ann Arbor and Legal Affairs Chairman L. A. Drolett, M.D., Lansing, were authorized to attend this Conference as AMA guests; in addition, Finance Committee Chairman O. B. McGillicuddy, M.D., of Lansing, and Messrs. H. W. Brenneman and M. A. Riley were authorized to attend.
- Upper Peninsula Medical Society, June 16-17, and the AMA Annual Meeting, June 26-30: Representatives to attend these two meetings were authorized.

Report on AMA Council On Education and Hospitals

The February 4 meeting of the AMA Council on Education and Hospitals in Chicago was limited to representatives of the Council on Education and Hospitals and representatives from some nine states in the Chicago area. The meeting was introduced by Dr. McKittrick and hope expressed that there would be a free interchange of ideas as to how the Council on Education and Hospitals could be of greater service to the State Societies.

Dr. Caldwell gave a brief discussion of some of the functions of the Council in regard to internship and residency programs; such as:

1. developing the Essentials of the approved residency and Essentials of the approved internship as to standards of training required in these areas—
2. developing methods of inspection of hospitals applying for intern and residency approval—
3. development of intern and residency review committees to review applications of hospitals applying for such approval.

Dr. Wescoe, another member of the Council who is Vice Chancellor at the University of Kansas Medical School, presented briefly the Council's activities in: (1) the recruitment of students, (2) the availability of scholarships and loans, and (3) discussed in general the problems of financing medical education. He further pointed out that the Council made surveys of each of the medical schools about every seven years to ascertain the general policy of the curriculum, the availability of teachers and several other problems concerning medical education as it related to the particular school. He indicated that such visits were not made on a policing basis but rather with the idea of offering helpful criticism and suggestions to improve and raise the standards of medical education.

Dr. John Z. Bowers, a third member of the Council and Dean of the University of Wisconsin, discussed the Council's roll as it related to allied medical professions; for example, the ophthalmologist and optometrist, the psychologist and psychiatrist, the pathologist and clinical laboratory worker. His committee had to do the accrediting programs in related health professions in physical therapy, medical technology, x-ray technology, medical libraries, etc.

Dr. Walter S. Wiggins, a member and secretary of the Council, discussed the council's activities in relation to foreign graduates and ways and means by which members of the Council might help to up-grade the caliber of foreign medical education.

After these general discussions, Dr. McKittrick

pointed out that the Council would be most receptive to suggestions from members present as to how the Council might be of greater service to each state and county medical society in the above mentioned areas. One suggestion made seemed to be quite acceptable—that State Societies have matching committees comparable to the Committee on Education and Hospitals. Such a committee should be well-balanced with physicians interested in education and in practice, who would be in position to assist the Council on Hospitals and Education of the American Medical Association by: (1) creating better dissemination of the Council's deliberations in the line of communication to the "grass roots", (2) to be able to assist the Council in developing better training programs within the hospitals of the State, (3) to provide better co-ordination in developing methods of financing medical educations, (4) making it possible to interest more physicians in the problems of recruiting students to the health fields.

I believe there are not more than five or six county medical societies in Michigan now having some type of loan funds or scholarships for medical students. This is an area very much in need of development and expansion and I believe that by using the facilities of the Council and their "know how" we could successfully broaden these areas in the State of Michigan.

HARRY A. TOWSLEY, M.D.

Speak to Clubs

Nine talks were presented by MSMS members in conjunction with the 1961 MCI. The addresses were given to service clubs in the Metropolitan Detroit area.

The list included C. H. Ross, M.D., Ann Arbor, who addressed the Detroit Kiwanis No. 1 Club, on "Male Change of Life;" K. L. Krabbenhoft, M.D., Detroit, the Excalibur Club, on "Radiation Protection and Nuclear Medicine;" L. A. Pratt, M.D., Detroit, the Kiwanis Club of Central Detroit, on "Lung Cancer and Its Relation to Smoking;" A. Blain, III, M.D., Detroit, the Detroit Group Representatives Association, on "Rising Insurance Cost, Over Utilization of Insurance and Increased Cost of Hospital Care and Doctors' Fees;" D. A. Sargent, M.D., Detroit, the Exchange Club of Detroit, on "The Relationship to, and Society's Responsibilities for, Mental Illness to Crime"; Lewis Hoffman, M.D., Detroit, the Christ Memorial Ev. Lutheran Church Men's Club, on "Who Needs a Psychiatrist;" C. J. Hipps, M.D., Detroit, the Royal Oak Exchange Club, on "Plastic Surgery;" G. S. Beckett, M.D., Detroit, the Caravan Shrine Club, on "Psychiatry;" and J. G. Bielawski, M.D., Detroit, the Cass Tech Pre-Med Club, on "Development of the Heart."

What They Said About 1961 MCI

"I wish to take this opportunity to thank you and your staff for your supreme and indefatigable efforts in connection with our Program Committee for the Michigan Clinical Institute. I would think that the Discussion Group's program could be expanded for next year as long as there is a careful selection of subject material."

JOHN W. SIGLER, M.D., Detroit

"Having arrived home safely, I hasten to let you know how much I enjoyed participation in the meeting in Detroit. It seemed to me a very well attended and excellently planned meeting and I believe your organization should be congratulated on such fine arrangements."

JOHN L. KEELEY, M.D., Chicago
(Guest Essayist)

"I want to thank you for the opportunity to participate in your recent meetings of the Michigan Clinical Institute and to congratulate you upon the hospitality that was shown me by my host."

ALVIN L. WATNE, M.D., Buffalo, N. Y.
(Guest Essayist)

"I want to thank you for everything that you did for me during my visit to the Michigan Clinical Institute and for the privilege of presenting the Pharmaceutical Lecture. The visit was a very pleasant one for me."

CHESTER S. KEEFER, M.D., Boston
(Guest Essayist)

"I am writing to express my most grateful thanks for the wonderfully cordial and hospitable manner in which I was treated on the occasion of my participation in the recent Michigan Clinical Institute. This entire experience was a most satisfying one which I enjoyed immensely. All of the arrangements which were made in advance on my behalf contributed enormously to the ease of my participation."

D. N. DANFORTH, M.D., Evanston, Ill.
(Guest Essayist)

"I want to express my thanks for being invited to participate in the program. I was very impressed with the program this year and I think that it offered many opportunities for the physicians, not only in general practice but in the specialty areas, to learn from the panel arrangement type of discussions that were presented.

R. W. BAILEY, M.D., Ann Arbor
(Guest Essayist)

"My wife and I, thanks to you and your group, had a most enjoyable stay in Detroit. The meeting was very stimulating and I carried away from it a good deal more than I brought to it.

"Thanks again for your warm hospitality and the pleasure of having met so many stimulating doctors."

EDWARD C. MANN, M.D., New York City
(Guest Essayist)

(Photo below)

Leaders for an evening symposium about the older person prepare to take the platform. A Hazen Price, M.D. *(standing)*, Detroit, was the chairman, aided by *(left to right, seated)*, A. H. Hirschfeld, M.D., Detroit; Raymond W. Waggoner, M.D., Ann Arbor, and Jack Weinberg, M.D., Chicago.

Mrs. Esther G. Regnaert *(left)*, Grosse Pointe Farms, chairman for the Fourth Annual Educational Seminar for the Michigan State Medical Assistants Society, studies the Seminar program with Mrs. Betty Lou Willey, Port Huron, MSMAS president.

Photos Help to Tell MCI Story

Eight Discussion Groups, an innovation this year at MCI, drew fine attendance at 8 a.m. in the morning! Directing the discussion on "Newer Drugs in the Treatment of Pregnancy Toxemia" were *(left to right)*: Charles S. Stevenson, M.D., Detroit; David N. Danforth, M.D., Evanston, and Arthur G. Seski, M.D., Detroit.

A citation was presented to Charles P. Bailey, M.D. *(left)*, New York, a pioneer in surgery of heart valve, by Earle Ingham Carr, M.D., Lansing, president of the Michigan Foundation for Medical and Health Education. Doctor Bailey gave the MFMHE Lecture, an annual MCI highlight.

The annual Conference for Residents, Interns and Senior Medical Students took a look at the costs of medical education. Panel patricipants *(left to right)*, were: Dean G. H. Scott of the Wayne State University School of Medicine; Associate Dean J. C. Caughey, M.D., Western Reserve School of Medicine; Wm. Bromme, M.D., Detroit, moderator for the panel; Dean W. N. Hubbard, M.D., of the University of Michigan Medical School and Walter S. Wiggins, M.D., Chicago, AMA Council on Medical Education secretary.

The annual Michigan Cancer Coordinating Committee Lecture was presented by Anthony R. Curreri, M.D. *(center)*, Madison, Wisconsin, who received a certification of appreciation from James W. Hubly, M.D., Battle Creek, chairman of the Cancer Coordinating Committee. At left is Harry N. Nelson, M.D., Detroit, former chairman.

MCI Attendance Report

Final attendance figures for the 1961 Michigan Clinical Institute hit 2,626, including 1,450 doctors of medicine. Further study of the figures reveals that sixteen different specialties were represented and that doctors attended from 157 different Michigan communities. The breakdown is as follows:

REGISTRATION BY SPECIALTIES

	Wayne County	*Outstate*
Anesthesiology	6	2
Dermatology-Syphilology	3	—
Gastroenterology-Proctology	12	6
General Practice	187	172
Medicine	75	39
Nervous and Mental	6	9
Obstetrics-Gynecology	73	30
Occupational Medicine	12	4
Ophthalmology	9	2
Otolaryngology	2	4
Pathology	10	5
Pediatrics	99	60
Public Health	7	18
Radiology	4	2
Surgery	89	75
Urology	2	—
Residents and Interns	215	66
Specialty not given	73	74
	884	568

M.D.'S OUTSIDE OF MICHIGAN

Canada	29	Missouri	1
Illinois	6	New Jersey	1
Indiana	2	New York	3
Kentucky	1	Ohio	6
Maryland	1	Oklahoma	1
Massachusetts	2	Wisconsin	1

MICHIGAN M.D.'S

Adrian	3	Belleville	2
Allen Park	5	Berkley	2
Alpena	4	Birmingham	11
Ann Arbor	43	Brooklyn	2
Bad Axe	3	Cadillac	2
Battle Creek	14	Clare	2
Bay City	9	Clinton	2
Coldwater	3	Midland	9
Dearborn	41	Milan	2
Detroit	708	Monroe	9
Drayton Plains	2	Morenci	2
Durand	2	Mt. Clemens	7
Eloise	10	Mt. Pleasant	2
Farmington	4	Muskegon	11
Fenton	3	Newaygo	2
Ferndale	6	Northville	16
Flat Rock	3	Oak Park	6
Flint	52	Owosso	4
Fremont	3	Petoskey	2
Garden City	2	Pleasant Ridge	2
Grand Rapids	30	Plymouth	2
Grosse Pointe	11	Pontiac	22
Grosse Pointe Park	3	Port Huron	7
Grosse Pointe Shores	2	Rochester	4
Grosse Pointe Woods	3	Roseville	2
Hamtramck	3	Royal Oak	24
Hastings	4	Saginaw	16
Highland Park	13	St. Claire Shores	8
Howell	3	St. Johns	2
Hudson	2	Southfield	3
Inkster	3	Tecumseh	4
Ishpeming	3	Traverse City	5
Jackson	18	Utica	2
Kalamazoo	12	Warren	4
Lansing	41	Wayne	6
Lapeer	7	Wyandotte	14
Lincoln Park	5	Ypsilanti	6
Livonia	3	(Towns represented by one*)	79
Ludington	2		
Manistique	2	TOTAL	1452
Marquette	2		

*One (1) member attended from each of the following cities; Alma, Albion, Auburn Heights, Bangor, Birch Run, Breckenridge, Boyne City, Bridgeport, Brown City, Byron Center, Clarkston, Calumet, Capac, Cass City, Coleman, Charlevoix, Coopersville, Clawson, Chatham, Chelsea, Douglas, Essexville, East Jordan, Ecorse, Fowlerville, Frankenmuth, Grosse Pte. Farms, Grand Haven, Gaylord, Gladstone, Goodrich, Greenville, Grand Blanc, Huntington Woods, Harbor Beach, Hazel Park, Hillsdale, Hesperia, Holly, Holland, Hartford, Hemlock, Keego Harbor, Kalkaska, Lathrup, Linden, Lowell, Laurence, Manistee, Menominee, Middleville, Mt. Morris, Marshall, New Baltimore, Oakland, Onaway, Orchard Lake, Olivet, Rogers City, Remus, River Rouge, Richmond, Reed City, Southgate, Saugatuck, Sandusky, St. Ignace, Sanford, Sparta, Sturgis, St. Louis, Swartz Creek, Three Rivers, Trenton, Taylor, Williamston, Whitehall, Yale, Zeeland.

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Each Filmtab SURBEX-T represents:

Thiamine Mononitrate (B_1)	15 mg.
Riboflavin (B_2)	10 mg.
Nicotinamide	100 mg.
Pyridoxine Hydrochloride	5 mg.
Cobalamin (Vitamin B_{12})	4 mcg.
Calcium Pantothenate (as calcium pantothenate racemic)	20 mg.
Ascorbic Acid (as sodium ascorbate)	500 mg.
Desiccated Liver, N. F.	75 mg.
Liver Fraction 2, N. F.	75 mg.

Supplied in bottles of 100 and 1000

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Potent maintenance formulas —ideal for those who are "nutritionally run-down"

DAYALETS® Table bottles of 100. Bottles of 50, 250, 1000.

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Therapeutic formulas for more severe deficiencies—illness, infection, etc.

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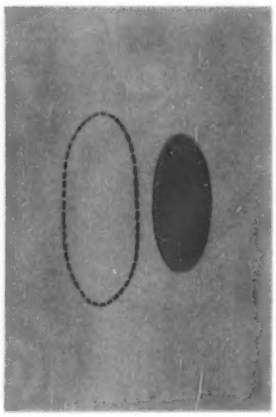
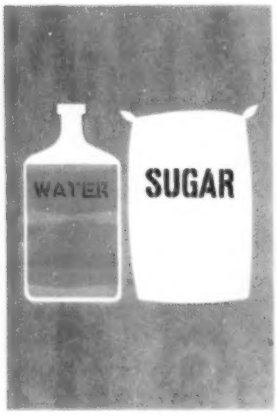


Tablets are easier to swallow, up to 30% smaller.

Vitamin after-taste and odor are eliminated.

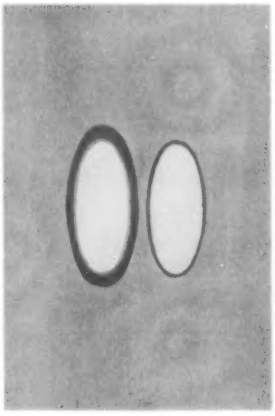
Tablets are pleasant tasting, non-caloric, come in a rainbow of cheerful colors.

Breakage and cracking are less likely. (Sugar coatings are crystalline, and more brittle.)



In contrast with sugar coatings, no water is used in manufacture.

This eliminates the need of protective subseals, and chances of moisture seepage through imperfections.



Absorption is speeded as sugar's bulk and subseals are eliminated.

Vitamins are readily available at proximal receptor sites.

NET RESULT: Potency is assured for a longer time. The patient gets what he pays for—and what you prescribe.

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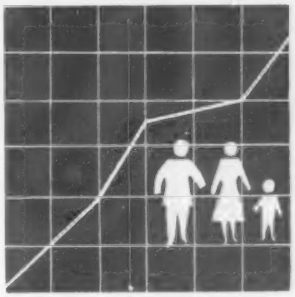
More than 120 million Americans, or two-thirds of the nation's civilian population, have achieved a substantial degree of financial security by protecting themselves with health insurance policies.

An estimated 132 million persons have hospital expense insurance, 120 million persons have surgical expense insurance, and 43 million workers—through formal plans—have their earnings protected by loss-of-income insurance. Millions of other workers had some degree of income protection through informal arrangements.

Major medical, little more than ten years old, now covers some 25 million persons.



Michigan Blue Cross Payments Hit New Record

Record payments of nearly $143-million for hospital care for Michigan Blue Cross members in 1960 put the plan in the red despite a record low operating cost of less than 3.5 per cent of income. The 22nd annual Blue Cross report said an increase in hospital costs coupled with needed use of more services by more members sent outgo over income by $1,724,000 (M) with that amount drawn from reserves.

The 1960 payments to hospitals hit $142,743,000 (M), 8.3 per cent higher than 1959. However, income, geared to a rate set in January of 1959, remained virtually unchanged. The report said hospital admissions for Blue Cross members hit an all-time high of over 576,000.

Joins Blue Shield Plan

Medical Mutual of Cleveland, Inc., a medical-surgical Plan serving a five county area in northeastern Ohio, has been accepted as an active member of the National Association of Blue Shield Plans. The Cleveland-based Plan, which now can use the Blue Shield symbol and name, was organized in 1945 and has enrolled more than 1,115,000 members since then.

Medical Mutual of Cleveland brings to 75 the number of Blue Shield Plans and affiliates in the United States and Canada.

Michigan Health Council Holds Conference

The Michigan Health Council State Conference will be held at Flint Junior College May 23-May 25, 1961. This year the Conference includes the 13th Annual Michigan Rural Health Conference, the 3rd Annual Michigan Health Careers State Conference, and the 1st Michigan Conference of the Joint Council to Improve the Health Care of the Aged.

Conference officials are Harry A. Towsley, M.D., Ann Arbor, General Chairman, and John A. Doherty, East Lansing, Secretary.

"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L.: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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Same formula as PABALATE-SODIUM FREE, plus hydrocortisone (alcohol) . . . 2.5 mg.

1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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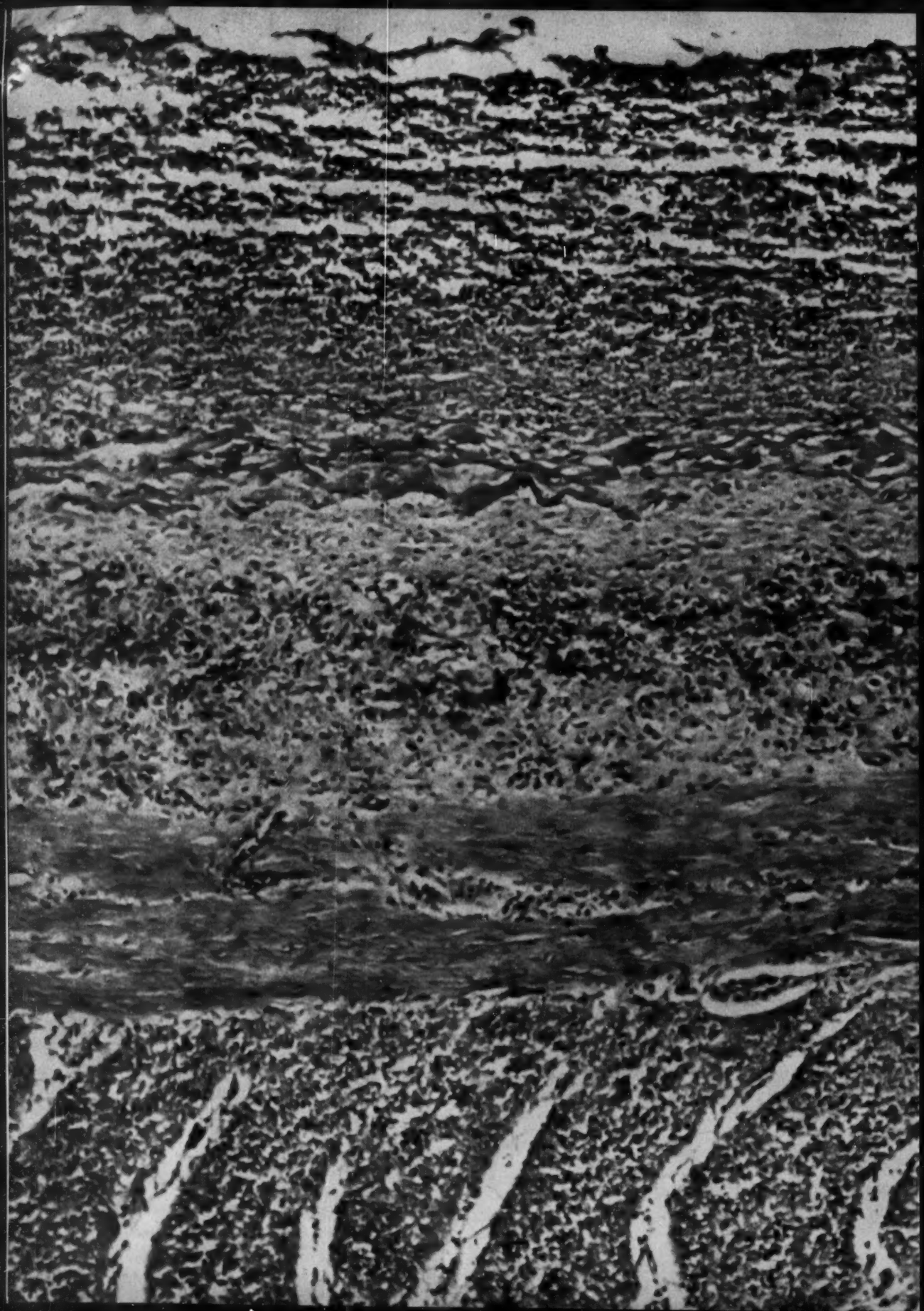

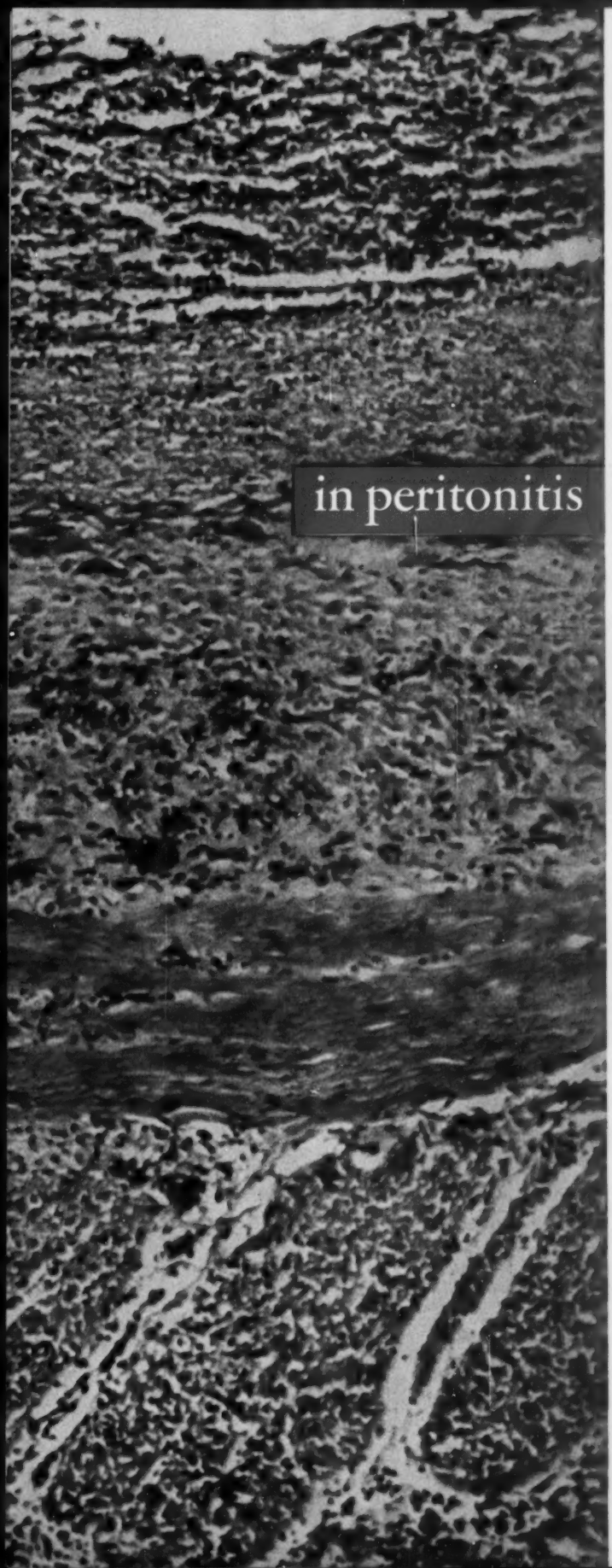

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Supplied: **Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.**

Adult dosage: **2 capsules four times a day.**

Side effects: **Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.**

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests.

Urticaria and maculopapular dermatitis, a few cases of leukopenia, and agranulocytosis have been reported in patients treated with Albamycin. All of these side effects rapidly disappeared upon discontinuance of the drug.

Caution: **Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.**

As with any serious infection, therapy of peritonitis with Panalba or other antibacterial agents is adjunctive to surgical procedures and supportive therapy.

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Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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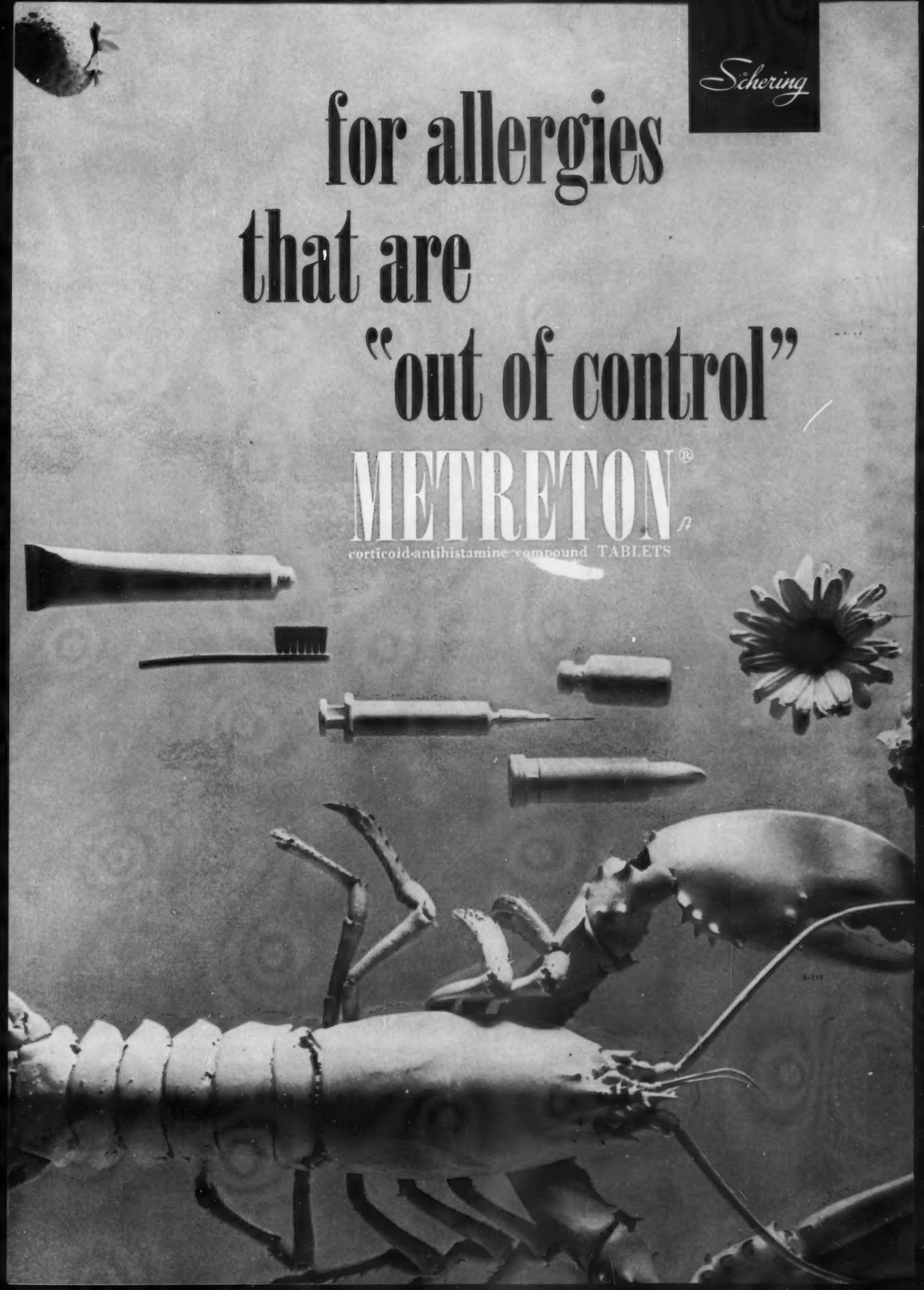

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moderate disability but able to work.

severely disabled but not totally incapacitated.

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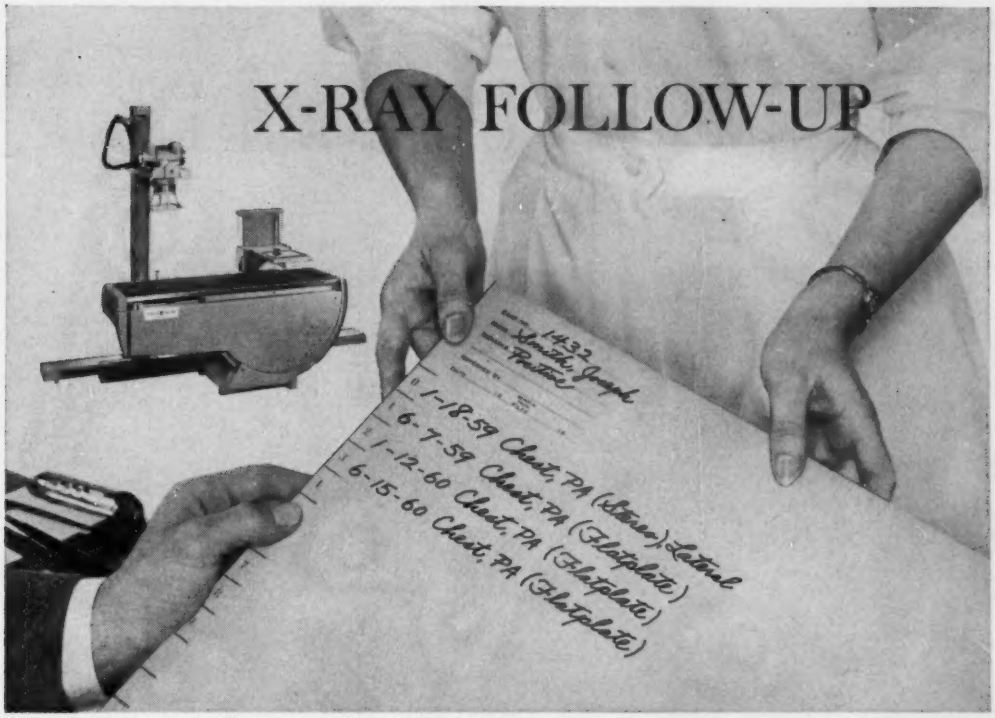

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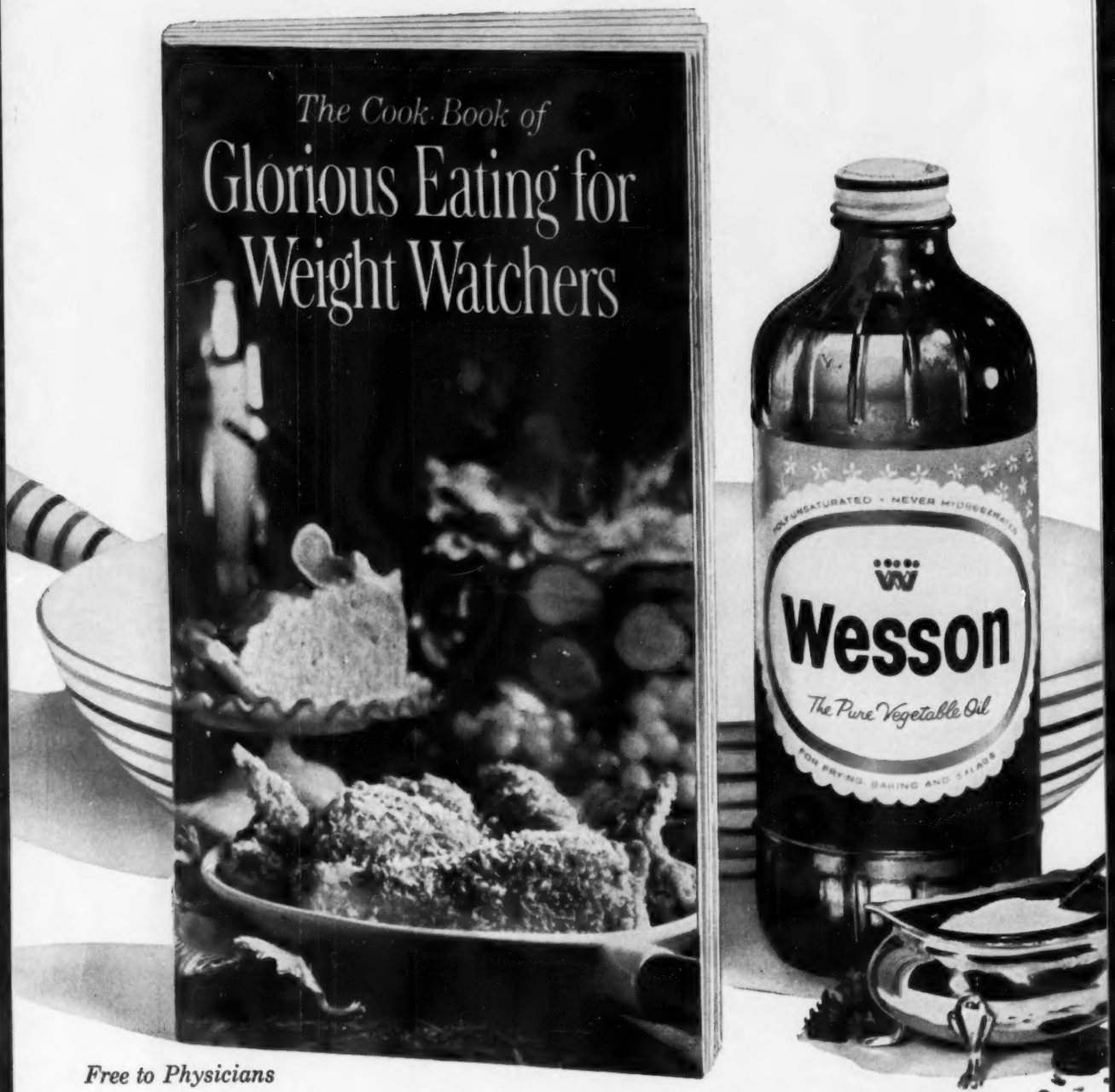

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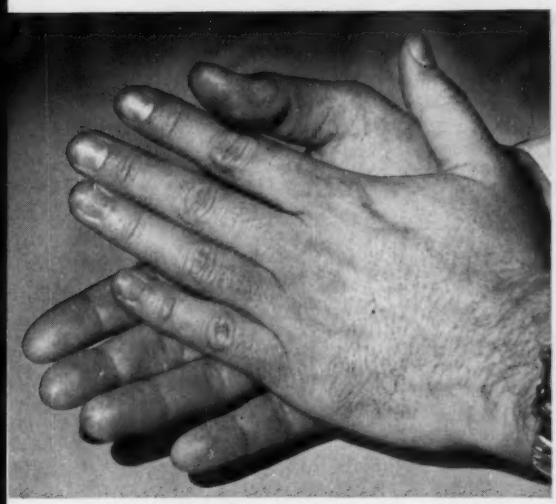

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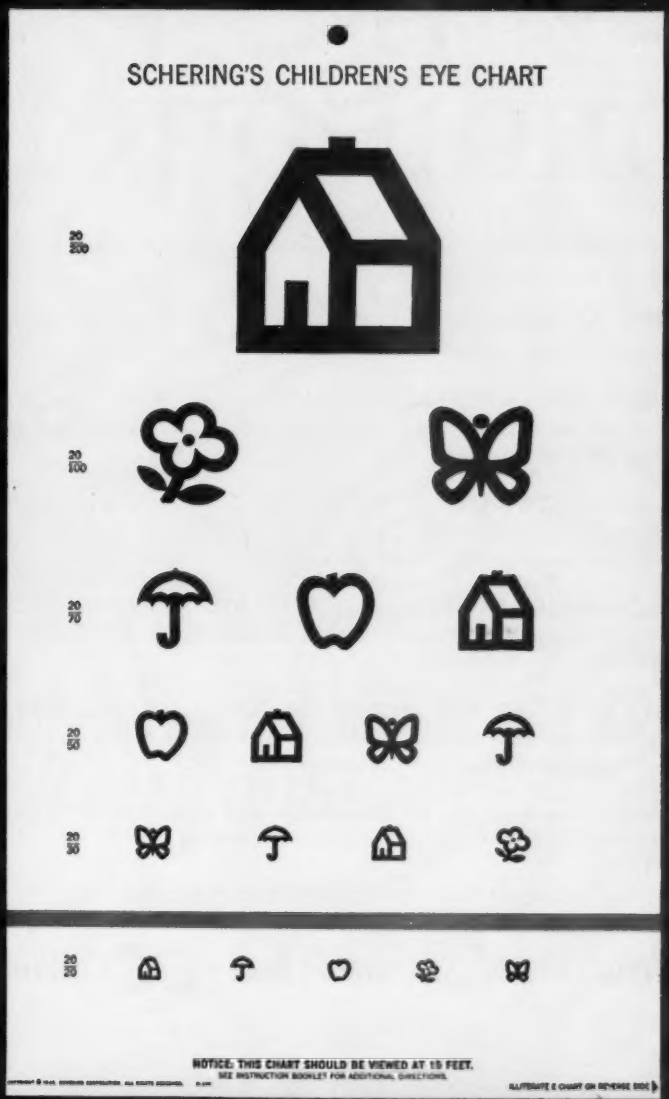

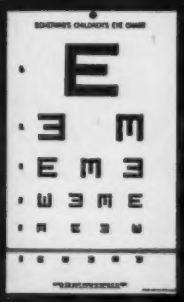

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Pancreatitis: A Clinician's Viewpoint

John B. Gross, M.D.
Rochester, Minnesota

CLINICALLY, three principal forms of pancreatitis are recognized: (1) acute edematous, interstitial, (2) acute hemorrhagic, necrotic, and (3) chronic. The clinical picture of each of these three forms will be surveyed briefly herein, and the matter of diagnostic criteria then will be considered. Certain special aspects of pancreatitis have been emphasized recently and deserve some comment. Finally, the management of patients with pancreatitis will be discussed.

Clinical Varieties

Acute Edematous Pancreatitis.—It seems possible that mild, *edematous* pancreatitis occurs more frequently than is appreciated. Every physician has encountered persons who could recall having experienced one or more isolated episodes of mild or moderate, steady, boring transepigastric pain, persisting all day and into the night, and unattended by chills, fever or jaundice. Often, slight epigastric tenderness has been associated. Such attacks may not have been severe enough to warrant calling a physician, or, if such was done, the diagnosis may have been pylorospasm, "gastritis" or "acute indigestion." Roentgenologic studies later may reveal no evidence of gallstones or peptic ulcer. Many such instances probably represent evanescent, mild edema of the pancreas which has escaped recognition.

Attacks of the sort just described, but more severe, may result in admission of the patient to the hospital. Determination of the serum amylase during the acute attack commonly will afford evidence to corroborate the clinical suspicion of pancreatitis. If acute cholecystitis is the working diagnosis, laparotomy is performed. Usually no stones are found in the gallbladder, although the organ may appear to be mildly inflamed, and the pancreas is described as being "slightly thickened." As a rule, the surgical findings are unimpressive, and there is no evidence of hemorrhage or parenchymal necrosis. It is this variety of pancreatitis about which Elman and Archibald wrote some thirty years ago.

There is circumstantial evidence to support the concept that acute edematous pancreatitis may occur and pass unrecognized, apparently unaccompanied by pain of note. Evans and associates found no men-

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Read at the meeting of the Michigan State Medical Society, Detroit, Michigan, September 27, 1960.

From the Section of Medicine, Mayo Clinic and Mayo Foundation. The Mayo Foundation, Rochester, Minnesota, is a part of the Graduate School of the University of Minnesota.

tion of abdominal pain in the records of fifteen of twenty-five cases in which acute or subacute interstitial pancreatitis was detected incidentally at necropsy.

Mild attacks of pancreatitis, such as described, generally do not require hospitalization and often a physician is not consulted. At most, analgesia and simple supportive measures suffice.

Acute Hemorrhagic Pancreatitis.—The clinical picture in those afflicted with acute *hemorrhagic* pancreatitis is in sharp contrast to that just described, for in such cases there is no doubt that something dramatic has occurred, and the patient is hospitalized promptly. The upper abdominal pain is acute, progressively more severe, steady, and prolonged; attacks may persist for days. The abdomen is tender, and evidences of peritoneal irritation and shock are the rule. If looked for, Turner's sign may be apparent in the loins during the attack. Nausea, vomiting and low-grade fever often occur, and usually mild-to-moderate polymorphonuclear leukocytosis is found. Values for amylase in the serum and urine, as well as for serum lipase, may increase tenfold or more during the attack. Hypocalcemia, thought to result mainly from deposition of calcium in areas of fat necrosis which involve the pancreas and which may be widespread throughout the peritoneal cavity, is common; values less than 7 or 7.5 mg. per 100 ml. of serum portend a poor prognosis.

The management of such patients is a joint project for physician and surgeon, although reasonable certainty in regard to the diagnosis calls for continued application of conservative measures designed to relieve pain, put the pancreas at rest, restore the blood volume to normal, combat hypocalcemia and support the patient otherwise by the intravenous administration of fluids, glucose, electrolytes and vitamins. Cortisone is not indicated. Antibiotic agents may be useful, as noted later.

The consensus is that operative intervention is indicated when: (a) there is doubt concerning the diagnosis, and some other acute intra-abdominal catastrophe is suspected, (b) stone in the common bile duct is likely and (c) the complications of abscess or pseudocyst of the pancreas supervene.

If gallstones are demonstrable or known to be present, cholecystectomy should be performed, usually after the acute attack has subsided.

Acute hemorrhagic pancreatitis has proved fatal in a minority (25 to 30 per cent) of cases.[24] Although measures designed to maintain an adequate blood volume during the attack may aid in reducing mortality, as has been stressed by Elliott and associates, the occasional patient, overwhelmed by fulminating pancreatitis, does not survive, despite all therapeutic efforts.

Chronic Pancreatitis.—The clinician recognizes yet another form of pancreatitis: that which evolves over a period of years, in either continuous or relapsing fashion. Chronic, recurrent pancreatitis is the clinical variety of pancreatitis most commonly encountered, in my experience. Most patients seen during an attack of pancreatitis can recall previous similar episodes or will experience such bouts subsequently.

Chronic pancreatitis occurs three or four times more commonly in men than in women. By no means all patients in this category have used alcohol to excess, and gallstones are absent in most.[19] As a rule, chronic relapsing pancreatitis begins in the third or fourth decade of life, and attacks recur over a period of years. Although for most patients painful seizures increase in frequency, duration and severity as the years pass, this quickening of the tempo sometimes does not occur, and such fortunate persons may be comfortable for years between the bouts of pain. Occasionally, one gets the clinical impression that the pancreatitis in a given patient is dormant and likely to remain inactive; in such instances it is commonly said that the pancreatitis has "burned itself out." Still, it is unwise to conclude that in such persons recrudescences may not occur at some future time.

The clinical picture of chronic relapsing pancreatitis has been described in detail previously.[7,18,20] The attacks of pain often vary somewhat in severity, and sometimes are mild enough to suggest edematous pancreatitis, but more often they are severe enough to require repeated injections of opiate over a period of days, thus resembling more the acute hemorrhagic form of the disease. The seizures of chronic relapsing pancreatitis generally are not attended by shock, however, nor are they likely to be lethal.

The pain of pancreatitis is located in the upper part of the abdomen, often beginning in the epigastrium and

The Author

JOHN B. GROSS

M.D.

spreading thence into either hypochondrium or both (more characteristically the left), upward into the lower, anterior part of the thorax, and through to the midportion of the back. Generally, the onset of pain is gradual, with progressive increase in the intensity of the pain over a period of several hours. Attacks may begin abruptly, however, sometimes during acute emotional upsets. Characteristically the pain is steady and boring; colicky pain is unusual unless the disease is complicated by stones in the biliary tree. The duration of the pain is an important diagnostic clue, for typically the pain lasts for days at a time—two or three days most often, but sometimes for a week or more. After a number of years of recurrent attacks, a stage often is reached at which one attack merges with another, so that the patient cannot recall having been entirely free of epigastric pain for weeks or months. During the painful seizure the patient often prefers to bend forward or to assume the knee-chest position. Nausea and vomiting, as well as anorexia, are common accompaniments of the acute seizure, although fever generally is low grade and transient or absent altogether.

Epigastric and left subcostal tenderness is the most frequent physical concomitant. Turner's sign is observed uncommonly and lack of rigidity of the abdominal wall is notable.

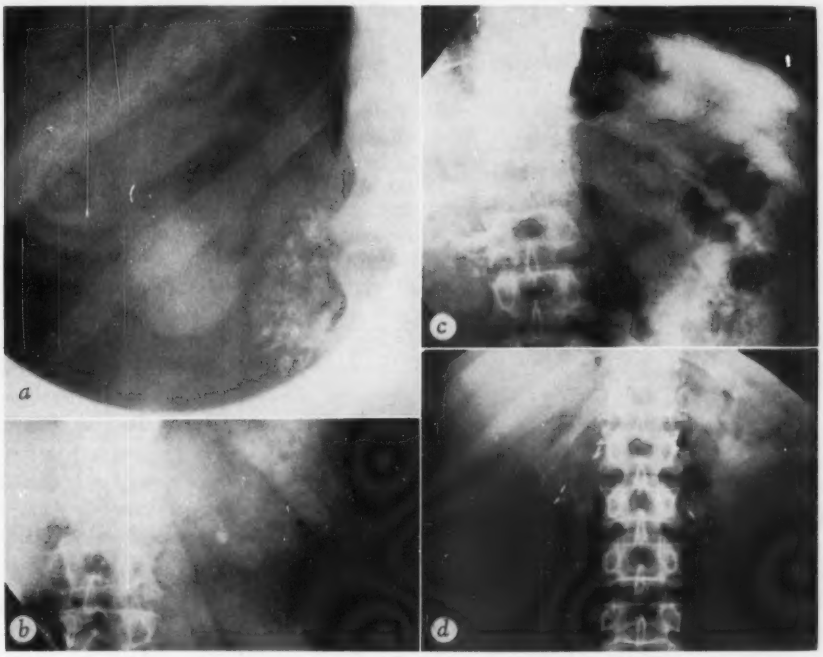

Fig. 1. Pancreatic calcifications, showing various patterns: (a) racemose throughout head of pancreas; (b) miliary and duct stone formed in tail of pancreas 4½ years after removal of several stones from the duct of Wirsung in the head of the gland; (c) amorphous calcific material in the head of the pancreas; (d) small calculi apparently within pancreatic ducts in the head of the pancreas.

As with edematous or hemorrhagic pancreatitis, during acute attacks the values for amylase in the serum and urine usually are increased during the first few days and those for serum lipase may be increased as well. Hypocalcemia is not uncommon; serial determinations show a gradual return to normal values as the attack subsides. Transient hyperglycemia and glycosuria occur occasionally during attacks.

Late in the course of chronic pancreatitis, as parenchymal destruction and fibrosis progress, the sequelae of pancreatitis make their appearance: pancreatic calcifications, external pancreatic insufficiency (steatorrhea and azotorrhea) and permanent diabetes mellitus. These may appear at different stages and may occur singly or in combination. The calcifications

(Fig. 1) sometimes present a lacy, filigree, racemose appearance or may form calculi in the larger pancreatic ducts. Over a period of years the calcifications may increase slowly in size, number and density, and a greater area of the pancreas may be affected. The diabetes caused by pancreatitic destruction of islet cells is similar to that occurring in persons who do not have pancreatitis. Steatorrhea and azotorrhea may be marked enough to be detected by gross examination of the stools; certain demonstration and accurate quantitation, however, depend upon careful performance of intake-excretion studies, especially when the external pancreatic insufficiency is not of marked degree.[11,39]

TABLE I. PANCREATITIS: DIAGNOSTIC CRITERIA

Presumptive
History
"Gray Zone"
History plus increased values for enzymes in serum and urine
History plus surgeon's description
History plus elevations of enzyme content of serum and urine plus surgeon's description
History plus sequelae
History plus family history
Sequelae alone
Surgeon's description
Definite
Surgeon's description (hemorrhage and necrosis)
Pathologic confirmation (alone or with any of above)
Sequelae (especially calcifications)

Chronic pancreatitis may occur without clinically significant pain, as emphasized by Bartholomew and Comfort. This diagnosis is apparent in the occasional patient who undergoes surgical exploration to ascertain the basis for painless jaundice of obstructive type; at operation there may be considerable difficulty in determining whether the pancreatic mass is benign or malignant. In other cases the pancreatitic sequelae of calcifications and steatorrhea, alone or together, may serve to focus attention on the pancreas when pain has been largely lacking. Rarely, the patient may complain only of painless enlargement of the upper part of the abdomen, which results from pancreatic pseudocyst, a complication of pancreatitis.

Diagnosis

In many cases the diagnosis of pancreatitis is not difficult. The history often is sufficiently clear cut and distinctive to enable one to suspect pancreatitis rather strongly. However, on the basis of the history alone only a presumptive diagnosis is possible (Table I). If operation is carried out and pathologic study of excised pancreatic tissue shows edema, hemorrhage, parenchymal or fat necrosis, fibrosis or calcifications, the diagnosis is established. When pancreatic calcifications are demonstrable roentgenologically, the diagnosis also is definite. Clear-cut demonstration of external pancreatic insufficiency likewise erases uncertainty. Diabetes mellitus without other sequelae of pancreatitis is less diagnostic, since diabetes occurs so commonly in the absence of pancreatitis.

As indicated in Table I, there is a sizable diagnostic "gray zone" of cases, to which generalizations do not apply well. In such cases the patients must be considered individually. In the alcoholic patient who has experienced recurrent attacks of severe and prolonged upper abdominal pain, each attack requiring repeated doses of opiate for relief, and with markedly elevated values for serum amylase and lipase during a seizure, the diagnosis of chronic relapsing pancreatitis is on fairly safe ground. The same cannot be said of the diagnosis in the case of a nonalcoholic patient with atypical pain and normal or borderline values for serum or urinary enzymes. There are, obviously, shades of definiteness in this intermediate diagnostic group. When the sequelae or complications of pancreatitis are detectable, the diagnosis becomes more definite, as noted.

There is sometimes uncertainty as to how much reliance can be placed on the surgical findings. Again, these can be most definite and informative, as when severe hemorrhagic pancreatitis or extensive parenchymal or fat necrosis is found. The finding of pancreatic "tumor," with or without performance of biopsy, however, may leave room to suspect underlying carcinoma, and a surgical report of mild-to-moderate pancreatic enlargement or induration also has less diagnostic meaning. Even more confusion may follow the surgeon's report that the pancreas seemed normal; such an impression, particularly when operation is performed a few days or weeks after pain has subsided and early in the course of chronic pancreatitis, does not exclude that diagnosis.[21]

Most clinicians are now aware of the several conditions other than primary pancreatitis which may provoke increase in the values for serum amylase and lipase. Mumps, prior administration of opiates, intestinal obstruction, perforated peptic ulcer, peritonitis and renal insufficiency are potential diagnostic pitfalls in this connection.[20]

Recently, determination of the content of amylase

in the urine has been revived and employed more widely as a diagnostic tool in patients with active pancreatitis.[24] The available evidence suggests that the urinary excretion of amylase often remains high for days after the concentration in the serum has returned to normal. The observations of Gambill and my own limited experience with the urinary amylase test are in accord with this view. Since determination of the content of amylase in the urine can be performed on an accurately timed 2-hour specimen, the result is available within a few minutes, and the test is inexpensive and simple, it should prove useful in the diagnosis of pancreatitis.

Hereditary Pancreatitis

Since 1952 a number of interesting kindreds have been observed in multiple members of which pancreatitis has developed.[8,19,21] The first of these families was described by Comfort and Steinberg, who pointed out most of the essential clinical features. Since that time my associates and I have observed at least four other such kindreds, and both Jackson[27,28] and Doubilet have encountered a family. Apparently the condition is not so uncommon as might be supposed.

In its clinically recognizable form the condition probably is inherited as an autosomal dominant trait. Transmission, apparently in accordance with mendelian laws, justifies the designation of "hereditary" (rather than simply "familial") for this form of pancreatitis. Whether abortive or incomplete forms exist in some of the blood relatives, as happens in the case of cystic fibrosis, for example, is not known at present.

Hereditary pancreatitis makes its appearance early in life. The typical patient is a young adult, usually with a history of similar attacks recurrent since early childhood. Originally, females seemed more commonly affected than males but subsequent observations indicate that the incidence according to sex is approximately equal in the still-small population sample.

The hereditary form of pancreatitis clinically resembles the nonhereditary form of relapsing pancreatitis in most respects. Affected persons usually experience the same severe seizures of upper abdominal pain lasting for days at a time, necessitating repeated injections of opiate for relief, and frequently hospitalization for a week or more. Some attacks may be mild and evanescent, others severe and incapacitating. The same sequelae of diabetes mellitus, pancreatic calcifications and external pancreatic insufficiency may develop after sufficient destruction of the pancreatic parenchyma has occurred, and the complications of pseudocyst, abscess, gastrointestinal or retroperitoneal bleeding and addiction to opiates may occur also.

A few clinical features are peculiar to the hereditary type of pancreatitis. The principal difference from the nonhereditary disease, other than the familial involvement, is the early age at onset; hereditary pancreatitis is primarily a disease of children and young adult persons. Gallstones and alcoholic excesses have been encountered infrequently among persons with the hereditary disease. Interestingly, the calcific deposits in the pancreas in those with hereditary pancreatitis are mostly in the form of calculi in the larger pancreatic ducts, which fact probably has some significance, as yet undetermined.

It is likely that those with hereditary pancreatitis have inherited some predisposing abnormality, since the condition is transmitted in accordance with mendelian laws and since it becomes manifest so early in the lives of those affected. The nature of the inherited predisposing abnormality is not clear, although it is likely of a biochemical or metabolic character; in those examined at operation or necropsy to date we have not observed evidence of an anomalous arrangement of the pancreatic or bile ducts, nor of other anatomic abnormality. Microbiologic assays in some persons with hereditary pancreatitis, as well as in a few of their as yet seemingly nonpancreatitic blood relatives, have shown some abnormalities, chief of which is an amino-aciduria in which relatively large amounts of lysine are excreted.[19,22] That this amino-aciduria has any etiologic or pathogenetic significance in the development of pancreatitis in such persons is not established, however.

Pancreatitis and Hyperparathyroidism

In 1957 Jackson[26] and also Cope and associates described the clinical association of pancreatitis and hyperparathyroidism. The suggestion was made that the hyperparathyroid state in some way had given rise to the pancreatitis in these cases and a few previously recorded. The association of these two unusual diseases is interesting, not because large numbers of patients have been involved, but because (1) there is implicit in this association a cause-and-effect relationship, a provocative hint related to the pathogenesis of pancreatitis, and (2) for the clinician, a new diagnostic clue to either condition is suggested.

As indicated, the number of such patients described thus far is small—to the present, perhaps twenty-one.[6,10,13,19,25,28,31] However, only two[19,33] of the six

patients encountered thus far at the Mayo Clinic (four of them since 1958) have been reported upon, and apparently a similar situation obtains elsewhere.[9] In most of this group of twenty-five-odd cases one theme recurs with some regularity: upper abdominal pain develops, and a clinical diagnosis of pancreatitis is made. The content of calcium in the serum, determined in order to follow the course of the pancreatitis and with the anticipation of finding a low value, unexpectedly turns out to be high. The finding of persistent hypercalcemia suggests hyperparathyroidism, and eventually a parathyroid adenoma is removed.

In a number of such instances the pancreatitis is said to have abated after parathyroidectomy. This suggestive evidence and the remarkable familial involvement (two brothers and their mother) reported by Jackson and associates do support the idea that the hyperparathyroidism in some way has predisposed to recurrent pancreatitis in these patients. In most of the cases the duration of either of the two conditions apparently is not known; this is particularly true with respect to the hyperparathyroidism.

If hyperparathyroidism can lead to pancreatitis, what is the mechanism? One suggestion proposed is that the hypercalcemia favors formation of stones in the alkaline milieu of the pancreatic ducts, with resultant obstructive pancreatitis. Such an explanation might apply to those instances in which stones are found in the larger pancreatic ducts, but it is difficult to reconcile this hypothesis with the fact that no pancreatic calcifications have been noted in approximately half of the persons observed. Germaine to the matter is the recent work of Haverback and co-workers, showing that the addition *(in vitro)* of calcium ion to pancreatic juice until the concentration exceeds 7 milliequivalents per liter permits activation of trypsinogen by trypsin, a reaction postulated to be of importance in the pathogenesis of pancreatitis.* Also of some interest are the data obtained by Schilling and associates showing that both canine and human pancreatic tissue normally contains relatively high concentrations of calcium (compared with liver and muscle) and that the calcium content of inflamed canine and human pancreatic glands is markedly elevated. It should be observed, however, that a critical piece of evidence is still lacking; namely, the calcium content of juice from the pancreatic ducts of healthy persons and of patients with coexistent hyperparathyroidism and pancreatitis. The latter data should not be difficult to obtain if, at operation on such patients, the surgeons are alert to the opportunity presented.

The physician aware of the possible coexistence of hyperparathyroidism and pancreatitis, when confronted with either condition, will think of the other. In the patient with hyperparathyroidism and unexplained attacks of upper abdominal pain, the possibility of pancreatitis should come to mind. Conversely, the calcium content of the serum of each patient who has pancreatitis should be determined, not only to establish whether or not hypocalcemia is present, but also to bring evidence to bear on the possibility of hyperparathyroidism; it should be kept in mind that a tendency toward hypercalcemia may be masked temporarily if active pancreatitis is also present.

Pancreatitis and Hyperlipemia

This subject, reviewed recently,[1,19,30,36] will not be considered here in detail. It is appropriate to note, however, that occasionally patients with active pancreatitis are found to have turbid serum, which on analysis is found to contain high concentrations of lipids; also of interest is the occurrence of relapsing pancreatitis in some persons with familial hyperlipemia.

It is not known whether the hyperlipemia in such patients results from or provokes the pancreatitis, or whether both are perhaps consequences of some other metabolic derangement in the body. Experimental and clinical observations to date suggest that the concomitant occurrence of the two conditions is more than coincidental and probably is more frequent than has been realized. This fascinating relationship, inviting further study, doubtless holds important clues to the pathogenesis of some instances of pancreatitis.

Therapy

There are only a few guiding principles in the management of patients who have pancreatitis. One of these is general support of the patient, including relief of pain; another is to put the patient and the inflamed organ at rest; a third measure is removal of possible precipitating factors, to prevent future attacks, with consequent pancreatic destruction. It is obvious that the extent and character of the therapeutic measures will vary with the severity of the attack and with other circumstances in the individual patient. If the sequelae or complications of pancreatitis supervene, special treatment is in order.

The therapy of acute pancreatitis has been mentioned above. It is the consensus that acute pancreati-

*It may be noted that the work of Beck and associates questions the validity of this concept.

tis is best managed medically. Mild attacks may require little except rest in bed for a day or two and appropriate dietary limitation. Severe attacks may necessitate vigorous support in the form of the administration of blood, adequate doses of opiate for relief of pain (if nitroglycerin or other antispasmodic is unavailing), continuous gastric aspiration and parenteral replacement of water and electrolytes. Significant hypocalcemia calls for the intravenous administration of 10 ml. of a 10 per cent solution of calcium gluconate two or three times daily. If fever is present, one of the tetracycline antibiotic agents is given orally in doses of 500 mg. every six hours or intravenously every twelve hours to prevent secondary infection. A combination of 1,000,000 units of procaine penicillin and 1 gm. of streptomycin administered intramuscularly each day in divided doses seems equally satisfactory.

After the acute attack has subsided, an attempt is made to prevent further bouts of pancreatitis by advising the patient to avoid alcohol completely and permanently; to employ a bland diet, avoiding spices, large amounts of greasy foods and overloading of the stomach; and to obtain adequate rest and relaxation. Studies should be conducted a month or so after the acute seizure has subsided in order to exclude the presence of gallstones, hyperparathyroidism and persistent hyperlipemia. Cholecystectomy or, less often, removal of a hyperfunctioning parathyroid gland or adenoma may be indicated. The demonstration of persistent hyperlipemia invites trial of 1 gm. of nicotinic acid administered orally two or three times daily, or appropriate doses of triparanol (MER-29) or some other agent designed to bring the lipid content of the plasma to normal.

Late in the course of chronic pancreatitis, diabetes mellitus and external pancreatic insufficiency commonly are present. The diabetes calls for measures similar to those employed in the treatment of diabetes of the ordinary type; by extrapolation from experiments in animals with extirpation of the pancreas, severe diabetes resulting from destruction of the pancreatic islets should be largely refractory to the sulfonylurea compounds. Deficiency of external pancreatic secretion, with resultant steatorrhea and azotorrhea and attendant fecal losses of calcium and fat-soluble vitamins, can be controlled satisfactorily by administration of pancreatin or viokase tablets (each containing 0.3 gm. or 5 grains) in doses of 2 to 5 gm. with each meal, or one tablet to three tablets hourly when awake.[20,29]

The surgeon plays the major role in the treatment of severe and progressive chronic pancreatitis and its complications.[5,32,37,38] Many operations have been employed and none has been found entirely reliable. Choice of operation will depend on the circumstances in the individual case, as well as on the surgeon's experience and judgment at the time of operation. If gallstones are present, cholecystectomy and exploratory choledochostomy are indicated. At that time transduodenal sphincterotomy also may be carried out.

Internal or external biliary-drainage procedures have been followed by good results (prolonged periods of remission) in a half to two thirds of cases,[32] and distal pancreatectomy with retrograde pancreatojejunostomy has proved helpful in some cases in which there is obstruction of the pancreatic ducts in the head of the gland. Removal of calculi from the pancreatic ducts is accomplished when feasible. Total pancreatectomy rarely has been performed for intractable pancreatitis. Drainage of pancreatic abscesses and pseudocysts may be necessary. Splanchnicectomy has been followed by relief of pain for prolonged periods in some patients.

It is apparent that the treatment of pancreatitis is a combined medical and surgical endeavor, which must be individualized. In an unfortunate minority of cases all therapeutic efforts may fail to control the disease; a number of such patients eventually become demoralized, bankrupt and addicted to opiates. Complete rehabilitation then is indicated but often is impossible. In such cases the disease is truly malignant, though not neoplastic.

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"It's unwise to pay too much, but it's worse to pay too little. When you pay too much, you lose a little money—that is all. When you pay too little, you sometimes lose everything, because the thing you bought was incapable of doing the thing it was bought to do. The common law of business balance prohibits paying a little and getting a lot—it can't be done. If you deal with the lowest bidder, it is well to add something for the risk you run, and if you do that you will have enough to pay for something better."—JOHN RUSKIN (1819-1900).

Treatment of Arthritis with Guanido-Amino-Peptidase

A Preliminary Report

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ALTHOUGH the widely heralded ACTH, cortisone, and the many related steroids have done much to temporarily alleviate the symptoms of arthritis, this group of therapeutic agents is failing to fulfill the hope of a real cure. A high incidence of serious untoward reactions follows even recommended therapeutic dosage. Another drawback is the fact that when administration of steroids is stopped, the arthritic symptoms return, sometimes more severely than before treatment was initiated. The author, himself an arthritic (rheumatoid spondylitis), knows from his own personal experience, as well as from that of his patients, the true meaning of the consequences of false hope. But progress depends on utilizing the available information and adding to it the newer knowledge obtained from research.

The present report describes the results obtained in fifty arthritic patients with guanido-amino-peptidase, a guanidine-reducing enzyme.

Although some actions of enzymes have been known for many years both in medicine and in industry, the true significance of the important roles played by enzymes in health and disease are only now being established. In the field of arthritis, attention was called to the therapeutic value of specific enzymes by Blackberg,[1] one of my co-workers with guanido-amino-peptidase.

Working with adenosine-5-monophosphate, which is closely related to guanido-amino-peptidase, he demonstrated the important role played by this enzyme and many others in maintaining maximal functional efficiency of the body as a whole. After summarizing the known facts concerning the effectiveness of this enzyme in many diversified disturbances he stated:

> It helps us to understand how any disturbance resulting in a lack of AMP or other enzyme constituents may have a causal relationship with the many rheumatic disorders and directly or indirectly with other degenerative disease processes. . . . With each advance in the knowledge of cell chemistry and the structure and function of enzyme systems, we come closer to a definition of life and to a better understanding of the etiology, pathogenesis and treatment of disease. Replenishing the cells with the molecular components necessary for normal cellular activities is therefore the basis of this new approach to disease therapy and with it, the birth of a new age in medical science.

That guanidine may play a role in the etiology of some forms of arthritis has been proposed by several investigators.[2] A symposium by Krebs and Harris gives further evidence of the causal relationship between arthritis and enzyme imbalance:[3]

> Failure of an enzyme system to hydrolyze or "crack" food products sufficiently for their removal, will disrupt the normal functioning of these complex processes. More than likely, as an antecedent factor in arthritis, imbalance in an enzyme leaves cellular waste products insufficiently oxidized for proper handling by the kidneys or other excretory organs, thus admitting into the circulation toxic compounds that irritate the serous membranes of the body, particularly the extensively used joint membranes.

Procedure

Fifty patients, twenty men and thirty women, with various types of arthritis, who failed to respond to previous therapy were treated with guanido-amino-peptidase. They ranged in age from twenty-two years to seventy-five years. Diagnosis was made in accordance with the diagnostic standards of the American Rheumatism Society. They were classified as follows: rheu-

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matoid arthritis, 49 per cent; osteoarthritis, 37 per cent; mixed, 14 per cent.

Previous treatment varied and included salicylates, ACTH, cortisone, prednisone and other steroids, heat, diathermy and massage. Only patients who failed to benefit from previous treatment were included in this study.

The therapeutic agent being studied is guanido-amino-peptidase, an enzyme which acts on the potentially harmful guanidine and converts it to urea and ammonia, which are readily excreted or rendered harmless. Under normal conditions guanidine is metabolized, but in patients with rheumatoid arthritis there may be a disturbance either in the enzyme activity or other metabolic processes which may lead to an increase in guanidine. By the administration of guanido-amino-peptidase the guanidine is broken down to urea and ammonia and eliminated. This is not unlike many other diseases which are caused by impaired enzymatic activity and are therefore improved by restoring the needed enzyme. Gout, with its disturbed purine metabolism and accumulation of uric acid salts, is greatly benefited by any agent which helps eliminate the excess urates.

The guanido-amino-peptidase (Barthro) was administered intravenously in the form of an aqueous extract, buffered to the desired pH and activated for optimal enzymatic activity.* The dose of 5 cc. containing 2 Q units of active enzyme was injected intravenously every third day for six to twelve injections. One Q unit designates the enzymatic activity decomposing 1 mg. of a standardized substrate.

*Supplied in activated, standardized form under the trade name, Barthro, by Barry Laboratories, Detroit, Michigan.

Results

Because the patients included in this study were refractory to their previous therapy, their beneficial response to Barthro induced the author to prepare this preliminary report while additional studies are still in progress. Excellent results, with complete freedom of symptoms, occurred in 40 per cent of the patients treated. Good results, with return to pain-free activity —but persistence of irreparable tissue damage, occurred in 54 per cent. Poor results, with some diminution of pain but without restoration of normal function, occurred in 6 per cent. Although maximum doses were given for long periods, no toxicity or untoward reactions were observed in any of the patients treated.

Conclusion

Guanido-amino-peptidase was administered intravenously to fifty arthritic patients who failed to respond to previous therapy. Ninety-four per cent of the patients showed remission of symptoms and return to normal activities; 6 per cent showed a poor response although pain was relieved, and no untoward reactions or toxicity occurred in any of the patients.

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Prothrombin Synthesis in the Dog

Information was obtained on biosynthesis of prothrombin and how drugs such as coumadin and vitamin K_1 function at the cellular level. Flourescent anti-dog prothrombin was used to mark those dog liver cells containing prothrombin when prothrombin production was modified by drugs. Coincidental with sampling of the liver, blood was drawn for studies of circulating coagulation factors. It appears from these that normally liver parenchymal cells are engaged in cyclic asynchronous production of prothrombin. Studies of prothrombin-depleted dogs following coumadin treatment clearly show that the mechanism of action of this drug is to interfere directly with biosynthesis rather than to promote storage of prothrombin. Vitamin K_1 administered to such dogs promoted prothrombin synthesis.

A precise timing in the sequence of cellular and circulation events following vitamin K_1 treatment was found. First there was a lag phase while precursors were mobilized and sufficient quantities of prothrombin formed to be detected by the fluorescent antibody technique. Only a small increase in circulating prothrombin occurred over the next two and one-half hours, while more and more parenchymal cells were marked as actively engaged in prothrombin synthesis. During this period, the status of the circulating procoagulants as indicated by the one-stage assay returned to normal. The two and one-half- to four-hour period was one during which all of the liver parenchymal cells were stimulated to synchronous production of prothrombin with storage indicated by the most intense cellular fluorescence seen at any time. This was followed by a release period when cellular fluorescence decreased and circulating prothrombin increased to normal.

Vitamin K_1 given to normal dogs, also, promoted synchronous parenchymal cell activity with a small release of prothrombin to the circulation. It appears, however, that a regulatory mechanism exists which maintains the circulating prothrombin within limits by promoting either storage or release of prothrombin by liver parenchymal cells. (Supported in part by the Michigan Heart Association).—*Abstract of a paper presented by Gordon F. Anderson and Marion J. Barnhart of Wayne State University, before the Detroit Physiological Society, March 16, 1961.*

Pulsion Diverticulae of the Esophagus

A Report of Fifteen Cases Repaired by a Single-Stage Procedure

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Robert Hornbeck, M.D.
Donald Mehan, M.D.
Walter Stenborg, M.D.
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OUR REPORT includes a detailed account of our technique, results and observations. The salient features of this interesting condition and the evolution of its surgical correction are more abundant in the literature. We refer the reader to the detailed accounts of Harrington,[1] Sweet,[2] and McNeeley and Glassman.[3] The first descriptions of pharyngoesophageal diverticulae is generally credited to Ludlow in 1764, Bell in 1816, and Meckel in 1832.[4] However, it was not until 1877 that this defect became well known through the classic description of Zinker.[5] So remarkable was his presentation that this diverticulum is sometimes referred to as Zinker's Pouch. These early writers were joined by Goldman,[6] who described the original two-stage operation, C. H. Mayo,[7] E. Starr Judd,[8] and F. H. Leahy,[9] all of whom contributed greatly to the refinements of the two-stage procedure. The original interest in the two-stage procedure was stimulated by an effort to reduce the high incidence of postoperative mediastinitis, pneumonia and fistulae with which the earlier one-stage procedure was cursed. The mortality rate of early one-stage procedures was considerable and the two-stage operation did much to overcome this. The problems and complications that attended the single-stage procedure when first done were largely due to improper techniques and inattention to certain basic principles. The use of ponderous catgut sutures plus the cauterization, carbolization and inversion of the stump played prominent roles in the number of abscesses, fistulae, and the occasional cases of esophageal stenosis that were seen. Little heed was paid to the segmental blood supply of the esophagus, and the diligent care which must be exercised to avoid tissue trauma in esophageal work was not observed.

Author

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Generally speaking, diverticuli of the esophagus are usually divided into three main groupings: pulsion, traction, and super-diaphragmatic. Pulsion diverticuli, those with which we are concerned, are usually situated in the hypopharynx at the pharyngo-esophageal junction. Traction diverticuli are those usually confined to the mid-portion of the esophagus and are the result of inflammatory attachment to the esophagus by adjacent carinal nodes. The exact classification of super-diaphragmatic diverticuli has not been accurately determined. Actually, as Harrington[1] has stated, the term esophageal diverticulum is anatomically incorrect for two reasons. First, the diverticulum rarely is invested with a muscle coat and should therefore be termed more properly as saculation. Secondly, the mucosal herniation actually occurs through the muscle fibers of the pharynx and not the esophagus (Fig. 1). However, time, convenience, and tradition have firmly implanted the misnomer in the medical literature of today. Satisfactory proof for the acceptance of any one factor in the etiology of diverticuli has yet to be presented. Coburn[10] ascribes to the theory of congenital influences in describing the presence of a pharyngeal pouch in pigs and reports cases in a two-year-old and in an eight-year-old child. Congenital mal-developments of the hypopharynx, the esophageal pouch or the crico pharyngeal muscle would thus be predisposing factors to these pulsion diverticuli. King,[11] conversely, attributes the condition to the anatomic relationships of the cervical vertebrae to the fascia and extrinsic muscles of the esophagus. His detailed pharyngeal and esophageal anatomy, as they occur about the maturely developed larynx, and the relation to the cervical spine, plus his observations on the act of swallowing and the exertion of pressure on these anatomic deficiencies are convincing. We wish merely to state that in our relatively

small series, all of the patients have had swallowing difficulties attendant with upper dentures and a history of improper mastication.

The average age of the patients in our series has been sixty-three years. The youngest patient was forty-eight, the oldest eighty-three. The symptoms are essentially of six months to four years in duration. These include: dysphagia found in all fifteen patients, orthopnoea in six, hoarseness in seven, weight loss in twelve. All of the lesions were demonstrated by fluoroscopic x-ray examination with opaque media. In each case the lesion was endoscopically inspected, the diverticulum being visualized, so that the diameter of the orifice could be determined. The diverticuli were aspirated to determine bacteriologic content and also rid them of secretion prior to surgical extirpation.

Preoperative Preparation

The surgical preparation consists of: 1. The correction of dehydration and the alterations of body chemistry resulting from the near starvation diets. On occasion this has proven a difficult task. The use of the appropriate intravenous fluids or the feeding of a high caloric diet by a nasal gastric tube is sometimes necessary. If difficulty is encountered in the passage of the nasal tube to be used for feeding, it may be inserted at the initial esophagoscopy or it may be inserted by passing it down a string which the patient has previously swallowed. 2. An anti-bacteriologic program consisting of streptomycin and penicillin is given twice a day for two days prior to surgery. 3. Endoscopic examination of the true esophageal lumen and the diverticulum take-off with dilatation of the main esophageal lumen thus minimizes the danger of pressure rupture at the site of the closure of the pharynx following surgical repair. 4. As hoarseness is such a common complaint in this disease, all of the patients are subjected to direct laryngoscopic examination to rule out any co-existing pathology of the cord structures.

Surgical Technique

The operation was performed in all cases using gas, oxygen, and ether endotracheal positive pressure anesthesia. The results of this technique in this series was satisfactory. With the patient in the reverse Trendelenburg position, and the head extended, a small pillow is placed beneath the shoulder of the operative side, the head is turned toward the other side. Unless the P.A. film demonstrates the sac to be to the right of the midline, the left sternocleidomastoid is used as the line of incision. The incision is made parallel to this muscle fold, from the level of the prominence of the thyroid cartilage down to approximately 2 cm. above the clavicle. The usual incision is 7 to 8 cm. in length. The platysma is cut across in the line of incision and the superficial layers of the deep cervical

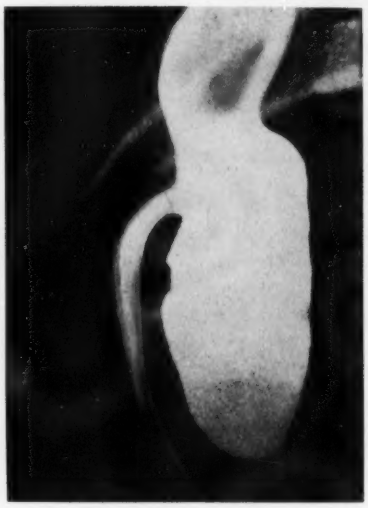

Fig. 1. Advanced diverticulum with a broad base. Case 8.

fascia are opened. This incision frees the sternocleidomastoid muscle so that it may be retracted laterally and pulls medially the sternothyroid and the inner belly of the omohyoid and thus exposes the carotid sheath. Dissection between the carotid sheath and the thyroid gland is readily accomplished by ligation of the middle thyroid veins. Retraction of the gland, medially, and of the carotid sheath laterally, exposes the esophageal bed. Remnants of the buccopharyngeal fascia bind the esophagus to the paravetebral fascia but simple blunt dissection readily frees the esophageal pharyngo junction and the base of the inferior constrictors, the cricoidius and the muscles that contribute to the sac of the diverticulum, at the upper end of the esophagus. The use of Green and Brewster retractors greatly aid the exposure so that the anatomic site of herniation can readily be visualized. Two points of importance in the isolation of and the resection of the sac are (1) accurate definition of the sac neck, and (2) preservation of two separate coats, the muscularis and the mucosa. Although the wall of the sac may have suffered multiple attacks of inflammatory change, leaving its walls thick and distorted, it is usually possible to outline the ruptured muscle layers as a fringed collar extending 1 to 1½ cm. onto the sac wall. This should be dissected free

with particular care given to hemostasis. If they are not completely separated, they may form a ridge over which a new diverticulum may form. The esophageal submucosal venous plexus may be troublesome in the presence of inflammation. It may be well, as Coburn suggests, to ligate this plexus early to avoid bleeding since even a small hematoma impairs the viability of the suture line. Having secured the exact mucosal neck of the sac and a free separate muscular layer, it is important to divide the neck of the sac flush with the cricoid muscle to prevent cutting on a bias. Guide sutures are secured in the muscular corners and a Duval lung clamp is placed across the sac's neck so that its forward jaw is parallel to the line of incision. For the mucosal approximation 0000 silk is used, cutting and sewing across the base with individual, interrupted sutures. No effort is made to invert the suture knot as is suggested by Sweet. The muscular layer is closed separately with 0000 silk. A small Penrose drain is left in the superficial portion of the wound and the fascial layers are closed with silk. The realignment of the muscularis of the esophagus obviously can only be in the plane of the constrictor fibers. However, the realignment or the suture line of the mucosa could be made and swung in almost any direction. The advantages of the method are: 1. There is no suture ridge or dimple for the start of a new sac. 2. The two angle closure strengthens the posterior pharyngeal wall as cross grained plywood adds strength to its respective thickness (Fig. 2).

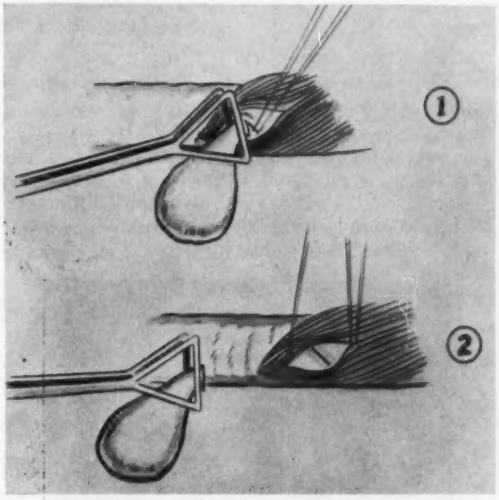

Fig. 2. Technique of sac resection with a two-angle closure of mucosa and muscularis.

Postoperative Care

The patients are returned to bed in a sitting position. They are allowed to sit on the side of the bed or be up on the first day. The Levine nasal tube is left in place for the first twenty-four hours to rid the gastrointestinal tract of gas and to prevent emesis. Fluid replacement is given by the intravenous route. On the morning of the third day, water by mouth is begun, one-half ounce per hour given in small sips; in six hours this quantity is increased to one ounce an hour, stress being laid on small sips; and at the end of the second six-hour period, water, in small sips, is given freely, by mouth. On the fourth postoperative day a clear liquid diet is prescribed and with the aid of our dietetic staff a progressive semi-soft diet for the next four days is given. Since Terramycin has been available, we have used it in quantities of six drops q two hours during the first and second postoperative days. This medication is dropped on the back of the tongue and we feel it is of value in controlling oral hygiene.

Results

In our fifteen cases there have been no deaths. Fourteen of the wounds healed by first intention, and in one case there was a small salivary fistula that closed spontaneously on the fifth postoperative day. All of the fifteen patients have been followed for over two years. The oldest follow-up is fifty-four months in duration. There have been no recurrences. All of the patients have been re-examined with barium swallow. In the patient who had the salivary fistula, we are unable, on fluoroscopic examination with Rugar, to demonstrate the site of this fistula. The swallowing mechanism is smooth and there has been no tendency to new pouch formation. One patient in the series had persistent swallowing difficulties for a four-month period. Direct esophageal examination by a Negus scope and dilatation of the true esophageal lumen apparently corrected this condition. All of the patients have been cautioned as to their eating habits. Ill fitting dentures have been replaced and the thoroughness of mastication has been stressed.

Conclusions

With the aid of antibiotics, accurate preoperative evaluation and preparation, exacting surgical technique and persistent postoperative care, we feel that the single stage resection of pulsion diverticulum of the esophagus has been reduced to a surgical exercise the risk of which is minimal, its complications few, and its results excellent.

(References on Page 613)

Quinine Idiosyncracy and Optic Atrophy

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IT IS a well-established clinical fact that certain individuals may suddenly become deaf and blind following the ingestion of quinine, even in small doses. The following case report illustrates that an idiosyncracy to quinine should be borne in mind as a cause of sudden bilateral blindness.

A nineteen-year-old white girl was admitted as an emergency to Wyandotte General Hospital on April 27, 1956, with the complaint of ringing in the ears and blindness of twenty-four hours' duration. Inquiry revealed that the patient had taken "several dozen quinine-cold-tablets" over the previous five days in an attempt to induce a miscarriage.

Physical examination revealed a frail, delicate girl, looking younger than her stated age. The pupils were fixed, widely dilated and did not react to light or to accommodation. The hearing was markedly impaired, and she could hear only the shouted voice. The remainder of the physical examination, including the neurological, gave negative findings. Spinal fluid examination was negative with no evidence of increased cerebrospinal fluid pressure. The initial impression was: bilateral optic neuritis and tinnitus, secondary to quinine poisoning.

The following day, when the patient was examined by Dr. J. M. LaBerge, she would not admit to light perception. The pupils were widely dilated and fixed. The vitreous was clear; the margins of the optic papilla were blurred, and the retina edematous. The retinal arterioles were spastic, and the macula stood out in bold relief, like the "cherry-red spot" seen after a central retinal artery occlusion.

After forty-eight hours, the tinnitus cleared, but the ocular fundus picture remained unchanged. On the tenth day, the patient admitted to light perception and showed nystagmus when bright light was flashed on the macula. On the twelfth day, the patient could count fingers at 2 feet, and the retinal vasospasm was alleviated slightly. (The essentials of treatment in hospital consisted of vasodilators and sedation.)

Following discharge from the hospital, the vision improved very little. On August 18, 1956, the patient was given Prednisolone orally and Vitamin B_{12} intramuscularly; however, after six weeks' therapy, the vision could be improved to light perception only in the right eye and counting fingers at four feet in the left eye, improving to 20/300 "at times" with pinhole.

On examination June 20, 1958, the visual acuity had not changed. The right eye was exotropic approximately 20 prism diopters, and the patient could not fixate well with either eye. The pupils were widely dilated, but did react sluggishly to light and to accommodation. On fundoscopic examination, the optic discs were pale and atrophic. The arterioles were attenuated, the veins showed sheathing; the retina was thinned and atrophic; a pigment clump was seen in the macula of the right eye. The visual fields were difficult to evaluate. In the right eye, the patient could detect a moving light nasally 5 degrees, inferiorly and temporally 10 degrees, and superiorly 15 degrees. In the left eye, she could detect the light 20 degrees nasally, superiorly and inferiorly, and 50 degrees temporally.

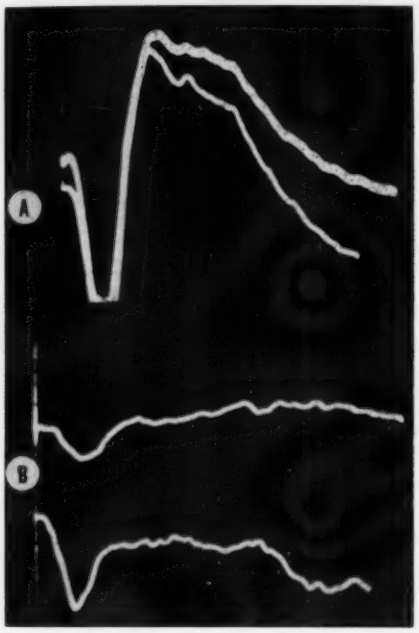

Fig. 1. Electroretinogram records. The upper tracing (a) is the response obtained in a "normal" eye; the lower tracing (b) is the record obtained following quinine optic atrophy.

An electroretinographic examination was carried out by Dr. A. D. Ruedemann, Jr., on July 25, 1958, at the Kresge Eye Institute. The ERG analysis revealed "a reduction in response to all light stimuli for both eyes. The highest b-wave amplitude for maximal intensity stimulus is only 88 microvolts for the right eye and 61 microvolts for the left eye. The normal range is 450 to 600 microvolts." (Fig. 1).

The patient's hearing, including audiogram study, was normal, in June, 1958.

Discussion and Comments

Proprietary medicines are taken for granted as "safe" drugs. Occasionally, an unduly sensitive individual reacts severely to these medicines, and the question again arises, "What are safe drugs?"

Quinine optic atrophy is a well-established clinical entity.[1] In years past, when quinine was a common remedy, the cases of ocular toxicity were widely reported. Dosages as low as 1 grain can produce visual symptoms in susceptible individuals.[2] The recently reported cases are sporadic, but dramatic.[3,4,5,6]

The toxic visual symptoms are of sudden onset, and bilateral. The effects range from the severe cases which display complete blindness and widely dilated, fixed pupils, to the mild cases which have slight amblyopia and contraction of the peripheral visual fileds. The prognosis is variable; some cases recover in hours, others require weeks. But most cases usually show a permanent contraction of the peripheral visual fields.

The pathogenesis of quinine visual toxicity is still not definitely known. Two theories have been proposed:

1. Direct toxicity on the ganglion cells in the retina
2. Retinal arteriolar vasoconstriction

Probably both factors play a role in the disease. Caminero[7] has suggested that "sensitized" individuals may have a delayed urinary excretion of quinine and thus become toxic.

Treatment of quinine amblyopia is still unsatisfactory. The following have been used, with limited success:

1. Vasodilators (e.g., Amyl nitrite, Priscolene®)
2. Paracentesis of the anterior chamber of the eye. (To maintain vasodilatation by way of hypotony)
3. ACTH[8]
4. B-Vitamins (e.g., Triamine, Nicotinamide,[9] B_{12})
5. Procaine injection of the superior cervical sympathetic ganglion[10]
6. Iodides[11]

Summary

A case report of toxic amblyopia due to quinine is presented. The severe and probably permanent visual impairment should caution the indiscriminate use of quinine in medicines readily available to the public without prescription.

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Trends in the Future of Private Practice

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ALL MAJOR ELEMENTS of medical care in the voluntary sector, i.e., hospitals and allied institutions, physicians, dentists and drugs, are under close scrutiny today. The private practice of medicine is experiencing increasing internal and external pressures which are reshaping its traditional forms. The overall situation is such that the quality of key decisions made in the next decade will determine whether the future practice of medicine is private or otherwise.

The purposes of this paper will be to examine the internal and external forces molding private practice, to view the concept of "privacy" in an historical setting, to identify the essential issues and to speculate on what all of this means to the practicing physician.

Internal Forces

The shape of private practice at any given point in time is determined by the product of internal and external forces, some acting in combination, others acting to neutralize one another. The ascendancy of any given set of formal or informal programs or developments upsets the equilibrium and quickly establishes a new set of relationships. It is a situation in which peripheral, hard to control, or hard to anticipate pressures can be determining, or initiative can carry the day. Because initiative is fundamental it behooves those supporting the concept of private practice to study and to try to understand the complexities and responsibilities of practice while the setting is still fluid. Initiative based solely on highly subjective outbursts is apt to be ineffective or even worse.

What are some important internal forces? Two stand out, (1) the growing complexity of medical science and (2) the supply of qualified practitioners.

Medical science seems to be growing at almost a geometric rate. This can be seen by controlling on diagnosis, age and sex and comparing the number and types of services rendered to patients in hospitals in 1958 as compared to 1938 or some earlier date.[1] It can be seen by a simple delineation of new advances in surgery, diagnosis or rehabilitation. As a direct result the art of medicine has become more complex. The challenge of successful application of basic insights has grown.

One outgrowth of the proliferation of medical science has been specialization. In 1931, 17.9 per cent of active, non-Federal, private practice physicians had a full time specialty, in 1959, 45.1 per cent did.[2] Over this time period, it became increasingly necessary to focus interest and practice in order to achieve sufficient quality and to rely on the consultation or referral help of other physicians in order to embrace family health care needs. It became true in and out of the hospital. The number of specialty boards grew from four in 1934 to nineteen in 1959.

Even within specialties, the flowering of medical science made it less and less possible for the individual practitioner to work alone. For many procedures, he needed essentially untransportable nurse, technician, peer and equipment help. Some procedures became possible in the office which were difficult or implausible at home, and many more became practicable only within the hospital. The rising percentage of office visits compared to home visits is a matter of record. The increasing use of the hospital is also evident. Between 1931 and 1958, the number of patient days of hospital use in general and special hospitals per 1,000 population rose from approximately 900 to 1,300.[3] During this time, not only the beds were used more actively, the emergency rooms and out-patient facilities also experienced greater traffic. The nature of the surgery or the tools needed to do a satisfactory job given the new state of knowledge often required it. Some of the tools, such as high voltage radiation or EEG, involved heavy capital investments making duplication at the sub-hospital level impossible and correspondingly, centralization (even among hospitals for some tools) necessary. The complexity of the work also demanded the centralization of manpower such as technicians for

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the sake of adequate training, supervision and control. As accuracy of test results became more important, the office was less able to match the hospital.

Most importantly, the forces of specialization and centralization led to the need for co-ordination and organization. Quality and economy of care as defensible objectives drew the solo practitioner into the orbit of the institution. Within this orbit, the physician became subjected to the requisites of group action at no little expense to his personal prejudices.

A second, important internal force is the availability of health manpower. The number of non-Federal physicians in private practice per 100,000 civilian population dropped from 108.4 in 1931 to 92.1 in 1959.[2] In 1959, the geographical distribution of the physicians in medical practice was very uneven. Considering all non-Federal, active physicians there was a range of from 95.9 per 100,000 civilians in the South to 154.4 per 100,000 civilians in the Northeast. In the greater metropolitan areas the rate was 158.4, in the isolated rural areas it was 47.4 with a steady progression in between. The difference is attributable largely to the distribution of full time specialists and hospital practitioners.[2] Physicians, particularly the full time specialists and house staff, tend to concentrate in densely populated, high per capita income, culturally rich areas.

The scarcity factor is difficult to assay. A declining ratio of physicians to population, even with the amplifying effect of new therapies and paramedical help, seems logically undesirable. In the absence of studies of physician supply based on a cross section study of population needs proving otherwise, the inference of a shortage is likely to persist. If a shortage does exist, one must speculate on the reasons why. Perhaps competing and newly emerging professions are alternately more attractive. Perhaps it is related to the fact that it is very expensive for a physician to get established today. Certainly, training periods are longer (even the general practitioners are now talking of a two year internship) and the investment in staff, equipment and rental in a busy office exceeds previous years.

The problems of supply and distribution tempt public action. If both persist, it is likely that government subsidy of medical schools and medical students will become a reality. Government money is rarely spent without a pattern in mind. And any pattern will probably contain elements of organization. Scarcity, *per se*, implies also that the drift from the home visit to use of the hospital will continue. It is demonstrably easier to see congregated than geographically disparate patients. Even the high expense of training has implications. A newly trained man with exhausted resources is apt to be interested in at least a partnership, possibly a group. If his training has been long enough, he may feel uncomfortable in the absence of formal allies even at the ambulatory level.

In similar and dissimilar ways, both the demands of medical science and the facts of medical manpower are confronting the private practitioner with the necessity of further organization and institutionalization.

External Forces

Several external forces impinge upon private practice. Some are more peripheral than others. Some are arbitrarily classified as external which might be called internal, but the dividing line is not a point at issue. Some of the more important forces are the following: large markets, costs, money volume, prepayment and insurance and selected qualitative considerations. Each is discussed briefly in turn.

Large Markets.—The market environment involving medical care has undergone a significant change in recent years and it promises to change further in the same direction. In a general sense, we see people moving from the farms and smaller towns to the metropolitan areas. Fewer and fewer people remain in their communities of birth. Regional differences and loyalties are being dissolved. In a residential sense, consolidation and bigness are becoming factors.

Organized labor has grown into manhood; the percentage of the total labor force in organized labor has almost doubled since 1920 with a noticeable tapering off of late. Several unions have developed large nationwide memberships and appreciable purchasing power or influence. A related growth has been that of large industry. Today a large percentage of the labor force works for industries and services doing business or with plants in more than one state.

Government has also grown markedly in the past few decades and it is still growing in response to such pressures as population increases, urbanization and industrialization. As the population has coalesced, the government has acted to make the internal forces bearable and to protect the individual against the directed interests of large groups. The growth has been stimulated also by such worthy objectives as national defense, highway construction, education and stabilization of the economy. The growth has taken

place at all levels—federal, state and local. It is highly likely that the growth will continue at a slower pace in the future involving greater and greater cooperation among all three levels with the Federal government playing a major role because of its superior money resources and its better developed administrative machinery.

Not only the size of market groups has changed. There has been a major change in character as well. The age composition of the population is in a state of change. The median age is rising and at the same time the population is growing older and younger. Mortality and morbidity patterns have changed. New savings in life are increasingly dependent on major victories against the diseases of middle and old age—for example, heart disease and cancer. There has been a remarkable increase in the average earnings per individual worker. He earns approximately three times today as much as his counterpart in 1900 after discounting the change in price level. Once more the wealth is more widely distributed. There is significantly wider car, home, insurance, etc., ownership today than even ten years ago. There has been an increase in the amount of schooling in most states.* People are becoming more interested in and better able to appreciate medical problems through more frequent exposure to doctors and to an increasing number of articles about health in popular and semi-popular media. They are more knowledgeable about medical care than ever before and more articulate about their wants. Social ideals have changed. The concept has grown that industry should protect the worker against the common hazards of life, through workmen's compensation, OASI, unemployment insurance, life insurance and health insurance. The courts have reflected the change in putting more emphasis on individual rather than property rights. Health is now often perceived or spoken of as a basic necessity ranking with food, clothing and shelter. There is no longer a question of whether people get it—only how. And in general, a preference has grown among most consumers for credit and time payments and for insurance, influenced originally perhaps by the withholding tax.

In summary.—The new market features large groups with impressive purchasing power willing to spend more on health as more and more of the necessities of life fall within their purchasing power, thoroughly conditioned to time payments and insurance, more articulate and specific about their perceived needs, standing for less and less regional contrast in either coverage or quality of care and tending to look upon good health as a necessity given the effectiveness of today's medical armamentarium.

Channeling the above general prejudices are four major groups: (1) government, (2) labor, (3) industry, and (4) prepayment and insurance. Among legislators at the federal and state levels, there is currently more interest in demand than need. Unable to get consistent testimony on need from professionals and interested always in constituent support, it was inevitable that the shift take place. The modern legislator holds the physician in less awe and he is more apt to support formalized action than he was as one result. Labor, in general, is desirous of including a major share of the medical care dollar under prepayment or insurance and through collective bargaining shift as much of the cost as possible to management. Management faced with the inevitability of paying more of the premium costs is beginning to share with labor a concern over overt controls so that concrete evidence is available that the money is well spent. This is particularly true in highly competitive lines. Prepayment and insurance stand between doctors and hospitals on one hand and consumer groups on the other uncertain about whether to rely sympathetically on professional solutions to problems or to exert some muscle from the outside in behalf of the consumer.

Rises in Medical Care Costs.—Between 1947-49 (base of 100) and 1959, the Consumer Price Index for all items increased 25 per cent; medical care as one major grouping increased 51 per cent, twice as much. Only transportation as a major grouping came close (46 per cent). All other major groupings increased less than 32 per cent. A breakdown of the medical care grouping reveals that the index for hospital room rates increased (107 per cent) over twice as much as general practitioner fees (44 per cent), about three times dentists' fees (34 per cent), over four times as much as surgical fees (25 per cent), and five times as much as prescriptions and drugs (21 per cent).

The peaking of the hospital cannot be passed off lightly by the private practitioners. Patients are not admitted, treated or discharged from creditable hos-

*In 1947, 42.3 per cent of the civilian noninstitutional population five to thirty-four years of age was enrolled in school. In 1959, the per cent was 55.5. Between 1946 and 1959, the total expenditure per pupil in daily attendance increased approximately 152 per cent in current dollars.

pitals without the signature of a physician. The high costs affirm the previously made point that the hospital is being used more actively. The fact that it is used without payment of rent or overhead by the physician, in most instances, behooves the physician to use it well. It should be added that the hospital is particularly vulnerable to inflation involving as it does many services that cannot be replaced by machines or formalized into rigid routines.

Large Volume of Money Spent on Medical Care.—In 1959, approximately $18.3 billion was spent on medical care exclusive of government expenditures on care, public health, public welfare, research and education. Adding government expenditures would push the total well over $20 billion. The amount of money spent by the public ranged between 4.0 per cent in 1948 and 5.4 per cent in 1959 of the public's disposable personal income, an increase of 35 per cent.[4] Such large sums for such an important purpose will not be spent without public interest in the future.

Visibility of Rising Costs.—Since the early 1930's, an increasing proportion of public medical care expenditures have been made through prepayment and insurance. This is particularly true of in-hospital doctor and hospital expenses. As a result, increases in some major costs are more quickly reflected in higher premiums or lower coverage and readily evident to many rather than the few becoming ill. Doctor's office, post-acute facility, drug and dental expenses are presently covered only minimally, but their inclusion in greater part at least seems only a matter of time. Cost changes, as a result, will become even more visible. Between 1948 and 1958, total accident and health premiums increased approximately 450 per cent; in 1958, they totaled almost $6 billion.

Allegations of Faulty Practice.—An active concern over quality of care has grown recently related to several factors. Greater sophistication among consumers has already been mentioned. In addition, there has been an increasing number of disturbing allegations of faulty practice. Some are rooted in rumor and exaggerated, secondhand accounts of individual experiences. Others, however, stem from specific studies.[5-8] Qualified investigators have revealed difficult to account for variations in practice, involving specific operations such as hysterectomies, related to the existence or absence of insurance or prepayment, and related to the organization of practice. The private practitioner will have to face up to these allegations in the future prepared with facts and figures of his own and prepared to change his ways where indicated.

Problem of Imbalance.—Among other external forces which might be mentioned, there has developed a fairly widespread concern with the balance of the private practice of medicine. In certain respects, facilities and programs seem overdeveloped, at least in some areas. The number of hospital beds required for general, short-term, and acute cases have more than kept pace with the population, and admissions per thousand population to these beds have risen 25 per cent between 1946 and 1959. At the same time, there has been a growing shortage of facilities and programs for preventive, post-acute and rehabilitative cases. Similarly, insurance and prepayment coverage have experienced an uneven growth. There is concern with over-insurance among a few people and lack of coverage for others, such as the aged, disabled and chronically ill. Some services are covered to the extent that misuse is suspected, and other services, for example, office practice or nursing homes, are covered only rarely.

The net effect of all these and other developments has been a growing interest in controls on the part of key consumer groups. Controls of all types are now discussed—moral, professional, financial and legal. The climate differs from the old days when there were unorganized, relatively uncritical patients, and when health issues were free of the strategems of collective bargaining and political enterprise.

Historical Setting

In the realm of medical care, the forces of centralization of authority, organization and institutionalization have been felt around the world. As is often stated, the United States is one of a few countries where private practice, as we know it, is so widespread. Within the United States, we can see these same forces affecting trades other than medicine. The professions of law and accounting have been affected. Even the basic scientist is now usually a part of a well-integrated whole, and industry itself is more highly organized and co-ordinated.

The United States differs from other countries in many significant ways, the experience of other countries regarding ownership may or may not be relevant. But the phenomena causing other segments of our economy to become institutionalized are acting also on medicine. Medical care, in fact, is particu-

larly vulnerable because of its intrinsic worth to the community. By looking back, the private practitioner can gain some appreciation that what is happening to him is not unique, some of it is the inevitable precipitate of basic changes in our economy and society.

The Problem

The problem facing private practice, in fact the whole voluntary movement, is fourfold. It is, in part, the classical problem of how to deal with high costs of essentials in a competitive, free enterprise economy. In part, it is a conflict between the planner, who distrusts the unpredictability of relatively free interaction and the element of chance implied in the absence of planned controls—and the entrepreneur. In part, it is the age-old battle over privilege between the professional purveyor (in many ways similar to the entrepreneur) and the consumer. Is the number of doctors needed a medical or a community decision? And, in part, it is the somewhat abrasive touching of two active worlds. On one hand is the broad environment where health is discussed incidental to other considerations (for example, raising take-home pay), where health is likely to be perceived only as a means to other ends. And on the other hand is the realm of service where what happens regarding prerogatives is of paramount importance—where health tends to become an end in itself and where ethics as well as practicable reasons are likely to grow in support of what is perceived to be right. The problem is subtly hidden at points, and it is often rationalized courageously, but the main elements are becoming more evident.

What Does This All Mean to Private Practice?

Although 28.9 per cent[9] of active physicians were on salary in the United States in 1959 working in government, hospitals, industry, teaching and research, the creed of medicine is still competition and individualism. This creed is sustained by the widely espoused psychology of the doctor-patient relationship, the feeling of independence growing out of the many years required to become a licensed practitioner and among other factors the relative shortage of physicians. The physician, in treating patients, becomes accustomed to making decisions and giving directions often without review or censure.

The creed is being subjected to stress. Better educated patients are beginning to question physicians in an attempt to understand the "whys" and to have some hand in helping themselves. Several professions now require many years of training and education leading to prestigeful positions. And among other developments, the clinical decisions of physicians are being tested by such mechanisms as medical audits and tissue committees, and their financial decisions are being questioned by the public. The change has been rapid in cultural eons.

The reaction of the physician to the changes in medical science, social orientation and organization has been in part defensive. Physicians refer frequently to the time when fees were set more on a paternalistic basis and largely unquestioned, and when the physician was a community in himself. A strong tendency exists to protect the autonomy and prerogatives of the physician by the physician through legal, economic, administrative and social means. The defense is interpreted by some as an anti-social, reactionary effort and by others more charitably as the adjustments of a profession to the inevitable consequences of institutionalization and centralization.

The concern of physicians about self-determination is expressed in various ways. At the local level, one sees efforts on the parts of physicians to get representation on boards of trustees of hospitals, to obtain the services of sympathetic M.D. administrators, and to resist organization beyond a certain point, saying that quality is too intangible to measure (medicine is an art). At the state level, one sees efforts to pass corporate practice of medicine legislation to protect the interests of the full-time specialists in the hospital (radiologist, pathologist, anesthesiologist and psychiatrist), to maintain physician control of Blue Shield and to keep the formulation of fee schedules within the society. At the national level, one finds organized lobbying against compulsory health insurance bills, and other official stands, most of which are highly conservative. At all three levels, local, state and national, organized medicine is concerning itself more and more with economic matters.

As much as, or perhaps more than, any profession, medicine has attempted to control its own ranks. The emphasis has been largely on a professional or moral plane and on quality rather than costs. The American Medical Association has made a distinct and successful effort to upgrade medical education. Today, only Grade A medical schools exist in the United States. In the early 1900's, this was not the case. Some nineteen specialty boards have been created by physicians to encourage and pass on extended training beyond medical school. Foreign medical student graduates are now screened by the

Educational Conference of Foreign Medical Graduates. And postgraduate educational programs are widely offered by such groups as the American College of Physicians and American College of Surgeons.

Economic controls *per se* have been minimal. State and local medical societies have concerned themselves with gross violations of charging practices, have helped develop fee schedules for the lower and middle income groups, and have helped to promote use committees in hospitals, but the leadership has not been aggressive or consistently well organized.

Given the environmental forces acting on private practice and the current posture of physicians, what are the implications—what does it all mean?

It means, purely and simply, that the scene is shifting and doctors must learn quickly to accept their new social and economic as well as clinical responsibilities. The changes taking place should not all be viewed as interloping or unrightful interference. Some must be accepted, others must be guided by affirmative action.

It should be clear that the physician has always had social and economic responsibilities. This is not a new motion. Not too many years ago, the physician wisely charged patient A less and patient B more, he gave a great deal of psychological support to the family, he harangued the druggist to produce high quality prescriptions, and he taught a wide variety of assistants, often informally.

The times have changed and so must the techniques. The physician must become concerned with the quality of the hospital, as he is with the quality of his office practice. He must be concerned about making prepayment and insurance work. They are here to stay, representing the patient's new form of payment. They give him less opportunity for discriminatory pricing, but they are as important to understand as patient A and patient B. He must have a philosophy toward the aging and aged as he once had about "Grandmother Jones." He must be articulate about the larger community in the same spirit that he could actively discuss familiar names and faces. And he must learn to use group action techniques, such as organization, administration, control and planning, to supplement the force of his own personality.

More Specifically

More specifically, what might the physician do? He should become more active in several ways.

Office—Here there is no substitute for a good history and physical, the proper (not profligate) use of diagnostic and treatment services, proper referral, and proper distinction between when the hospital or home is preferable to the office. In the office, finances should be discussed fully with the patient so that they are completely understood. The rationale behind fewer home calls must be discussed. There must be better communication with the patient about what is happening and why. And there must be less self-consciousness about physician groups. If a group enables a man to practice better medicine (he may feel it does or may not), he should welcome it rather than fight it.

Hospital—The physician must take active part in medical staff organization, even though at first it may seem a waste of his time. He must become more active on committees. He must insist that qualified men not be excluded from the staff for economic reasons. The problem of distribution is caused in part by the difficulty of young specialists getting established. He must promote rather than resist stronger boards of trustees and administrators. Without them, the hospital will drift to the disadvantage of the private practitioner.

Local Medical Society—The local medical society must concern itself with practice outside institutional boundaries at the local level, keeping in mind that a man is licensed to practice medicine and surgery for life even though he may be out of date in two years. Meetings must be held with key groups such as lawyers, executives, labor representatives, and legislators to discuss issues that are concrete with neighbors rather than to discuss abstract problems with unfamiliar persons. Physicians who step out of line financially or otherwise must be dealt with promptly and fairly.

State Medical Society—At this level, practitioners in concert must develop a better integrated philosophy—one that is flexible and realistic. They must sponsor studies to get dependable answers to contentious points about quality and abuse and then support the implementation of appropriate controls. They must develop strong pipelines to the state health department, the welfare department, the insurance commissioner and the legislature among others not for romance purposes entirely, but armed with useful facts, to educate. They must hire competent staff skilled in specific arts such as administration and research. They must concern themselves with placement of physicians.

National Medicine—Physicians at this level must change their image by acting differently in stressful situations. They must curb the tendency to depreciate almost reflexively other points of view. They must sponsor fact finding of a broad scope. They must support centralization (for example, Blue Shield) when it is necessary to meet national markets rather than to express continued concern about local prerogatives. And they must be ready with positive alternatives before the fact of crisis.

Prepayment and Insurance—First and foremost, physicians must practice sound medicine with an eye toward the economic consequences of prescriptions. They must be willing to produce standards and measures for use by prepayment and insurance agencies so that the public can be assured that all is going well. They must remember that prepayment and insurance have a marketing as well as a service side. They must accept that they need men at the helm who can wed sometimes contradictory issues and get things done. Such men should be actively sought and given wide scope of authority and responsibility. A private practioner cannot possibly know all he needs to know about social enterprise. It is all right for him to attempt to reflect common professional sentiments at the policy level, but to impose unrealistic biases not grounded in proper experience is likely to be fatal. The physicians need to develop a point of view toward prepayment versus insurance and then take a stand.

The above are some of many specific points that could be mentioned.

Conclusion

In the future, medical science will continue to grow at a fast rate, making the application of what is known even more complex than it is. Large markets will continue to be influential, as the bellweathers of consumer prejudice; costs will continue to rise, and prepayment and insurance, through extension, will give even greater visibility to the inherent problems of medical care.

If the private practitioner accepts some major changes as an understandable consequence of a maturing economy and learns to employ institutional techniques to influence other changes in the right direction—if the private practitioner is willing to devote time to medical politics or simply become informed, he may arrest the development of private practice at the level of a public utility, i.e., at a fusing of private and public interest. If he does not, given the cost, intrinsic value and political utility of community health, he runs the risk of public ownership through default in the not too distant future.

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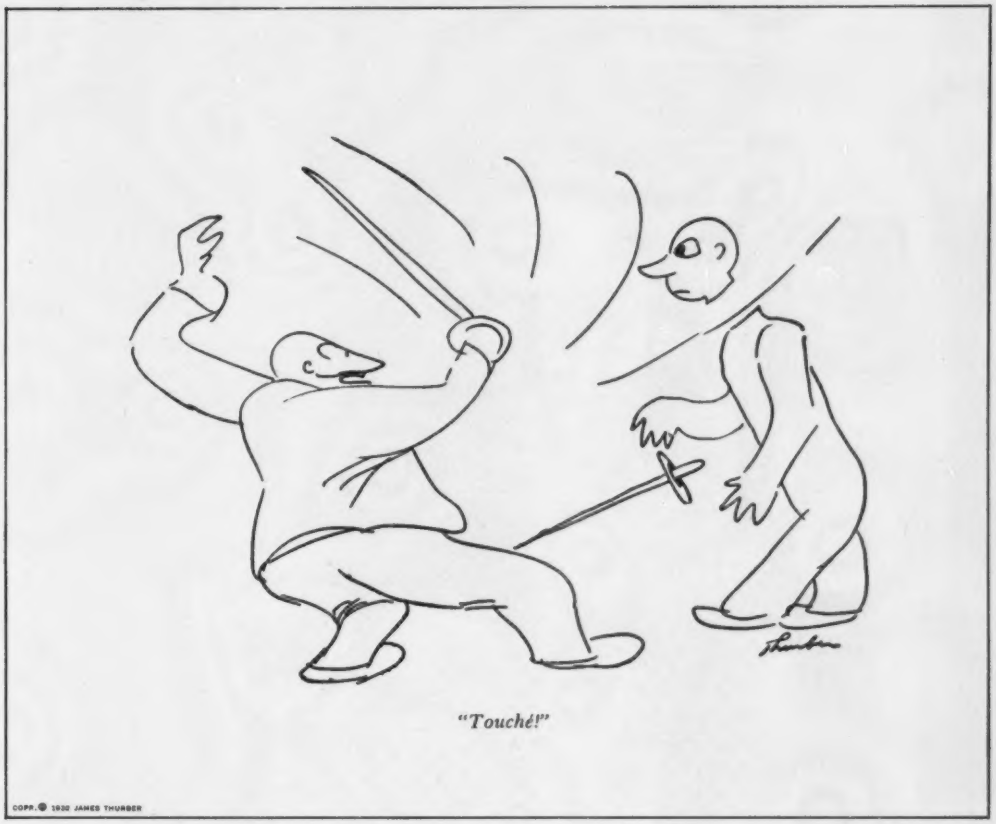
Present Status of Anticoagulant Therapy

Anticoagulant therapy has been discussed from the standpoint of the types of drugs available, their modes of action, methods of administration, methods of control, and individual advantages and disadvantages. Reasons have been suggested for existing differences of opinion as to the efficacy and safety of anticoagulant drugs.

In addition, more recently described and less well known effects of the prothrombin-depressant drugs have been discussed. They include: (1) uricosuric action, (2) bronchodilator effect, (3) reduction of plasma TAMe esterase activity, (4) influence on plasma lipoprotein levels, (5) acceleration of plasma lipid metabolism, (6) antagonistic action to increased blood coagulability resulting from lipemia, and (7) reduction in platelet agglutininability.—Abstract of paper presented by John H. Olwin, Presbyterian-St. Luke's Hospital, Chicago, at 1961 Symposium on Blood at Wayne State University.



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PATIENTS WHOSE APPETITES SHOULD NOT BE STIMULATED

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PATIENTS WITH HYPERTENSION

There was no blood pressure increase in any patient treated for bronchial asthma, and in some, blood pressure fell. Of these, three had been hypertensive.[4]

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Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of allergic respiratory disorders, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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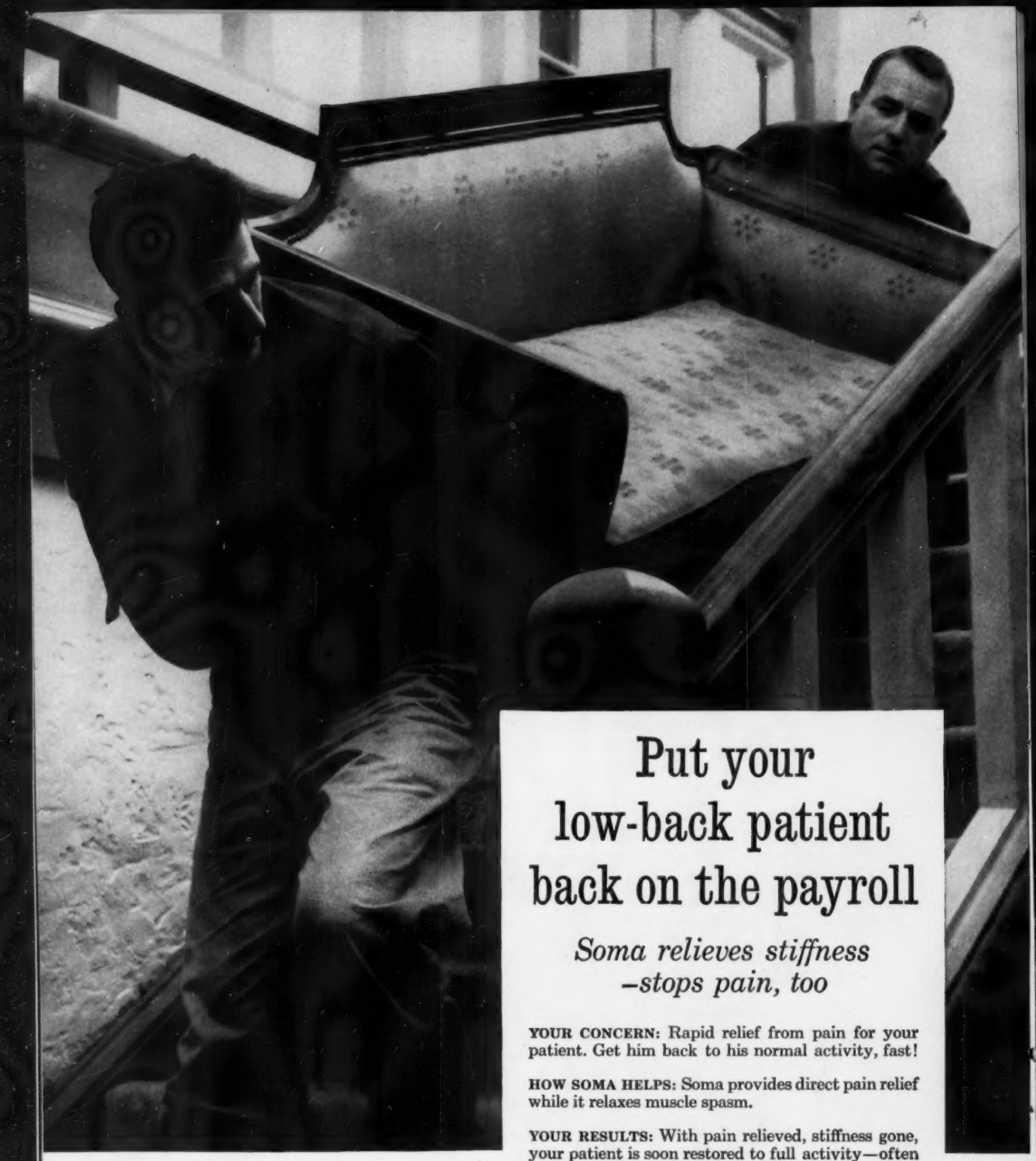

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Narcotics Addiction in Our Community Primarily an Educational Problem

John M. Dorsey, M.D.
Detroit, Michigan

"For what avail the plough or sail,
Or land or life, if freedom fail?"
EMERSON

OUR MICHIGAN community is truly and abundantly humane. Every one of its citizens naturally wants to live up to the highest level and magnitude of his human being, and needs to find out for himself just how he might achieve this goal. He is frequently aware of the grievous troubles which he has brought upon himself by lack of understanding, and often seeks ways to educate himself so that he may escape the awful consequences of ignorance and disregard. *He may not always realize the fact that there are degrees of knowing anything, and that the true measure of his fully knowing anything is his ability to act upon that knowledge in the most helpful way.*

For nearly all of the health disorders existing in our state, there is already activated citizen devotion towards securing adequate medical care. One most dangerous health deviation, drug addiction, continues to cry out to every kind and thoughtful citizen for his humane interest. That interest will not be withheld, once the citizen recognizes that his beloved homestead does harbor a terrible plague spot.

Next year completes a decade of continuous work of Detroit's Mayor's Committee for the Rehabilitation of Narcotic Addicts. Each member of this committee is thoroughly convinced that an educational campaign is the *specific* measure required in order to enable every citizen to learn for himself the gravity of the poisonous conditions existing in his very own immediate surroundings. Where drug addiction is, there is lack of informed civic spirit, slackening of respect for law, and cancelled enjoyment of peace. The fearful incidence of addiction to drug poisoning in our midst can be reduced only through the *force of education*, which means, through the force of every citizen's educating himself regarding its elimination, or its disastrous effects. This article reports some of my medical experience derived from alerting myself with regard to (1) established facts of existing drug addiction in my own community and (2) discovered facts as to how this disease of the soul, mind and body can be cleared up by reliably *practical* medical treatment.

Drug addiction itself is well defined as an overpowering impulse for intoxication by any drug possessing intoxicating properties; the overpowering influence of the drug succeeding the overpowering impulse for its use. The intoxication may be periodic or chronic. There is a tendency to increase the amount of the drug on account of the user's tendency to develop tolerance for it. The chief characteristic of the addict patient is his compulsion to use medicinal substance, either depressant or excitant, without benefit of medical insight and medical orientation. His satiety from his drug is essential to his going on living. He knows that, without special help, he cannot endure the pain, frustration and longing necessary for his curing himself. Opium and its derivatives such as morphine and heroin or, to a lesser extent, cocaine, produce best examples of extreme narcotization. Other examples of addicting drugs are well known, such as the barbiturates, marihuana, alcohol, paraldehyde, chloral, ether, and chloroform. Alcohol is usually considered separately as constituting the addiction of alcoholism. Love of money is the nature of the ideal that motivates illicit drug traffic of world-wide extent in what is suggestively called "junk." Self-preservation in one form or other is the nature of the ideal that motivates the patient to turn to illicit narcotics. His is what Peyton described as "a solitary shriek, the bubbling cry of some strong swimmer in agony." He may complain of his desperate health status chiefly by *avoiding* physicians except to secure his self-prescribed treatment.

The Author

JOHN M. DORSEY

M.D.

The awareness of the seriousness of drug addiction requires unremitting cultivation. In the opinion of every member of our Mayor's Committee, "the man on the street" has only the most fragmentary and incomplete knowledge of this grievous citizenship problem as it exists in his Detroit community. At the present time, there is an estimated total of 60,000 American drug-addicted persons, of whom about 46,000 have been officially reported. Whittier's spirited words apply again, "slaves—in a land of light and law." It is reliably estimated that there are in the neighborhood of at least 3,000 narcotic addicted fellow citizens of ours living in Detroit. According to the latest statistics compiled by the Federal Bureau of Narcotics, Detroit ranks fourth in the nation in the incidence of addiction.

The "narcotic habit," a highly important disease for every resident of the State of Michigan, particularly of our metropolitan Detroit area, is entirely too broad a subject for me to try to cover, and my physician reader knows that best. On the other hand, it is a community failure of most critical significance for every one of us. It is most disturbing, and we are most disturbed about it. I have elected to review this serious illness only from the standpoint of some of its major aspects, merely noting that its ideal therapy calls for highly trained experts (physicians, nurses, and medical assistants). As many a practicing physician can testify, treatment of his narcotically addicted patient tests all of his medical skill and personal insight. Each of my readers can add further detail through his own medical experiences.

> "Art thou less a slave because thy master loves and caresses thee?"
>
> PASCAL

The kind of individual prone to narcotic dependency is one whose appreciation of his life is not well developed. As a rule, he is discontented with his lot, feels discriminated against, underprivileged, and above all, *not loved and unable to love*. He lacks a sense of his own self-importance as an individual and tends to feel that the dignity of his individuality has been disregarded. He is lacking in self-reliance and inclined to seek someone else or something else to trust. His self-disesteem may show itself either in feelings of unhappiness and associated self-accusatory ideas of unworthiness, or in the ideas and feelings that his fellow men are not important, are not proper objects of esteem. By taking a drug, he succeeds both in feeling like a "somebody," and in withdrawing his interests from his uncaring fellow man. He enjoys toxic "equalizing" sensations which function as an artificial release from inferiority feelings and as a substitute for his natural self-respect.

The unscientific designation, "drug addict," includes persons of very different levels of mental development and, hence, of differing capacities for self-help. However, either through foreshortened mental development, or through regression from a more advanced to a more primitive kind of life orientation—or through both, a neglected drug-addicted person tends to feature certain conspicuous character traits. His extreme impulsive urgency to gratify his need for immediate freedom from mental tension is ostensibly his chief distinction.*

Basically, he seeks freedom from his feelings of unhappiness. His intoxication does not make him violent —quite the contrary. He is inclined to be passive. As one dependent patient volunteered, "The only time I would run, would be from the police or towards my drug." Another destitute patient confided, "My drug is like a baby's food formula. I am just like a baby. As soon as I get it, all I want to do is lie asleep in my crib. Without it, I have a powerless hopeless kind of life and feel that there is nothing I can do with my unhappiness." Unless he is able to secure adequate therapy, he may go on to increasing dependence upon his medication. His self-administered "dope" feeds his master passion, and, as Pope pictured it, "Like Aaron's serpent, swallows all the rest." The more drug he takes, the greater tolerance he develops, so that it requires increasing amounts of a drug to produce anything like the same artificially produced sensations of self-worth. Nevertheless, his drug continues to be his unenlightened first-aid, without which he could not care to go on living. *It is nothing less than a life-and-death struggle in which he finds himself.* Having himself told that he ought not be the way he is, is likely to be the extent of help he derives from his uninformed neighbor who cannot understand his extremity. My fellow man who helps himself with narcotics is saying, "Anyone extremely ill as I am needs, above all, to be able to live himself as cared for, as a worthy human being."

On the other hand, as he attempts to withdraw from his drug taking, he suffers unspeakable anguish. He undergoes exorbitant demands for money to meet his extortionate drug costs. His longing for his intoxica-

*In technical terms, he cannot renounce his archaic oral longing: his deep primitive desire for satiety, his passive narcissistic aim to be "taken care of." His genital organization undergoes undifferentiation and his drug becomes his all consuming love object. He maintains interest in his deliverer, the drug procurer. His preferred "touch with reality" is hypodermic.

tion, and his pain and terror without it, are so urgent that he cannot afford to be too particular about the way in which he secures this money. Thus, various kinds of private hell, even to the extent of destruction of human life, may become a part of his existence during such struggles.†

Evidence does not indicate that a narcotic addicted patient suffers irreversible mental deterioration. If he is able to recover his freedom from dependency upon the drug, and in turn from dependency upon his physician, he acquires the mental strength derivable from his successfully struggling through these difficulties, by suffering rendered sager, self-reliant, self-insightful. "Once an addict, always an addict" is no medical diagnosis. It is an understandable condemnation by one who has not yet been able to come to grips with, and renounce, his own defeatest *habit* of mind.

It is a well-established medical finding that the addicted person responds to proper treatment under confinement and will remain permanently cured when his drug using stops, and he is otherwise enabled to restore his health and strengthen his will power. Every instance of drug addiction is a unique one requiring *individual* study and treatment by a medical expert who has specialized in this particular field of drug addiction. Abstinence and the development of self-reliance based upon recognized self-knowledge, are the necessary steps back to healthy living.

"Narcotics Anonymous" is the name used by addiction suffering persons grouped courageously to combine their forces of resistance to addiction and of respect for the dignity of human individuality.

A Detroit citizen suffering from his ruthless and desperate addiction to drugs right now does not have the full opportunity he needs for recovering his health. He fears that he must live until he dies paying with his soul for his body's desire. Indeed he is skeptical as to whether there is any possible chance anyhow for him to restore himself, apart from his getting humane chemical detoxification to reduce the cost of his "habit." *He needs to be rescued.* It is the right and responsibility for each member of his family, neighborhood, and greater metropolitan community, to provide this hygienic rescue. It is peculiarly contra-indicated for an American citizen to be exploited by any form of forced servitude, and slavery to the "illicit drug traffic" is most offensive of all of life's circumstances.

†Only my seeing my personal identity in my "narcotic addict" can suffice to keep me working in this most difficult field, so easy is it for me to hate what I fear. However, it has been precisely through this kind of work that I have been able to develop a most cherished degree of medical hardihood.

"How happy is he born and taught that serveth not another's will"

WATTON

Man's effort to try to help himself get through his painful ordeals by using drugs occurred in his primitive ancestors, so that its beginning is lost in antiquity. It is only good sense to assume that his discovery of drugs for escaping pain and catching pleasure was one of his earliest findings. The first use of narcotics reported is that of people in what is now Iraq, 5000 B.C. The great Greek physician, Hippocrates, in the fourth century, B.C., recommended white poppy juices for a variety of illnesses. Early Egyptians knew of the important medical value of narcotics. The Spaniards while conquering and exploring Latin America found the natives were stimulating themselves by chewing the coca leaf, from which cocaine derived its name later.

Since the seventh century A.D., opium traffic has been known, and was begun by the Chinese. Paracelsus (1490-1540) eulogized it as "The Stone of Immortality." The Portugese and Dutch carried it on in the East before English merchants of Calcutta started it, when its control passed to the East India Company about 1781. Throughout the 19th century in Europe and in America, opium was used by the medical profession for almost every malady.** In 1803, Derasne separated the alkaloid base from opium and named it "Morphine." In 1845, a hypodermic syringe was invented by Rynd of Dublin, his hope being that injections would reduce the force characteristic of oral habituation. In 1898, Dresser, a German, discovered the opium derivative heroin, hopefully claiming it was not habit-forming and would cure opium addiction. Analogous discoveries and claims of "curative" drugs continue in our time.

Narcotics started deadening us Americans even before our Declaration of Independence. Successful rebellion against the tyranny of intoxication is not yet accomplished. Before the Civil War, the hypodermic needle was introduced here. In the latter half of the 19th century, drug addiction increased. "Panacea" medicines containing narcotics began to spread. At the end of the Civil War, estimated thousands of soldiers who had received numerous injections to relieve their sufferings from wounds and sicknesses, began to rely more and more heavily on this form of immediate and unfailing escape, as if satellites to a syringe. With the growth of advertising of patent

**See Dr. C. E. Terry's account, Encyclopedia of the Social Sciences, Vol. 5, page 243.

"remedies" containing narcotics, many other newly emancipated citizens became dependent upon the misusage of such medicines.

After World War II, heroin smuggling and peddling increased, and more teen-agers became problems of addiction. Commissioner of the U. S. Treasury Narcotics Bureau Anslinger, estimates 12 per cent (5,000 or 6,000) of addicted individuals are under age twenty-one. I am pleased to report that, in Detroit, this percentage is very much lower, and that for years now no cases of addiction have been found in our schools (thus far). However, it must be acknowledged, indescribably distressing as it is to do so, that every infant and child associated with an addicted person is a casualty of this dread disease.

Heroin has no official medical use in the United States, and is entirely a contraband chemical. Nevertheless, at the present time it, along with other illicitly sold drugs, provides outlaw trade in human character, including huge criminal financial profits. An addicted person may spend $5 or $10 to $100 or more a day to gratify his craving. It is estimated that an extremely high percentage of addicts (90 per cent) are involved in crime in order to be able to support their habit. This kind of spending, wild as it is, is not to be compared with the addicted person's extreme investment of his morality, of his ideals, in his soul-consuming illegal and non-medical use of drugs.

> "Oh! let me live my own, and die so too!"
> POPE

It appears that the first alarm about the dangers of narcotic habituation sounded in the 18th century when the Chinese emperor Yung Chen prohibited the smoking of opium. Reportedly, Chinese habitues paid little or no attention to their emperor's command. First international conference to control the narcotics traffic was held in Shanghai in 1909. Other meetings have been held at The Hague in 1912, 1913 and 1914 and at Genoa in 1920, 1924, 1925 and 1931. The chief problem in these conferences seemed to be how to limit narcotic production without restricting the revenue derived from it.

For well over a hundred years, the United States has had legislation attempting to restrict opium imports. In 1906, passage and enforcement of the Federal Pure Food and Drugs Act proved to be a very helpful measure. Meanwhile, members of the medical profession were becoming increasingly apprehensive of the employment of narcotic drugs. In the early 1900's, there was an increase of teen-age heroin addiction. During World War I, it was estimated that there was at least a total of 200,000 Americans addicted. The passing and enforcing of the Harrison Act of 1914 was another tremendous help. The purpose of this Act is to police the production and sale of narcotics, to make sure that drugs go through professional channels and are used only for medical and scientific purposes.

In 1930, the Federal Bureau of Narcotics was created in the United States Treasury Department at Washington. Additional national efforts to control narcotic usage have been: the Marihuana Tax Act, the Narcotic Drugs Import and Export Act, Controls of Synthetic Narcotics, and the Narcotic Control Act of 1956.

In 1935, the first federal hospital for the treatment of narcotic addicts was opened in Lexington, Kentucky. Now the Lexington and Fort Worth federal treatment facilities together have 2,200 beds. Federal hospital treatment was a most commendable development. It led ultimately to the full realization, now shared by all of its workers, that *local*, and not far-removed, hospitalization is the treatment requirement which must be heeded.*

The United States, along with more than eighty other nations, is working hard upon the control of narcotics both with respect to smuggling and transportation within our borders. Also federal and local narcotics bureau officers vigorously try to reduce theft of narcotics, forged prescriptions, and other sources of supply.

In this country, the effort to operate government-sponsored clinics to distribute narcotics to addicts appeared to make the whole situation worse. In 1924, a special committee report of physicians of the American Medical Association urged federal, state and local governments to exert full powers and authority to put an end to all manner of ambulatory methods of treatment of narcotic drug addiction whether practiced by a private physician or by the narcotic clinic dispensary. The report added that the only proper and scientific method of treating narcotic drug addiction is under complete control of both the addict and the drug by the physician directly responsible for the medical conduct of the addicted person's treatment. By the middle nineteen-twenties, all the clinics were discontinued. Condoning "free drug areas" instead of striving for "drug free areas" violated the spirit and purpose of international agreements and also demon-

*Dr. Murray A. Diamond, Medical Director, United States Public Health Service Hospital, Lexington, Kentucky—personal communication.

strated that drug addiction is a kind of health deviation which requires *compulsory* hospitalization. There is no such management as a "maintenance dosage," only increasing tolerance which means increasing appetite for greater amounts of the drug to produce the same amount of satisfaction.

In our metropolitan Detroit area as well as in the state and in the nation at large, every physician has been serving the cause of preventing and curing the mental and physical wretchedness known as "narcotics addiction." Our MSMS Mental Health Committee has been studying this problem for years, and many a helpful development is traceable to its efforts. Particularly, its members see the need for upholding the importance of making it an educational issue and for keeping it as a continuing study project. Not only in medical education but also in general education, efforts have been steadily exerted to clear up this critical public health ordeal.

The earliest recorded survey of narcotism in Michigan, of which I have knowledge, is that of O. Marshall in 1877: *The Opium Habit in Michigan*, Annual Report, Michigan State Board of Health, 1878.† Marshall's report was an incomplete one. In the first place, he had no data from the larger cities. Secondly, as he acknowledged, the information which he secured from physicians was less complete than would have been that secured from druggists. Thirdly, he used state population figures for 1874 instead of 1877. He calculated about 2,250 Michigan users. Marshall stated:

"At a meeting of the State Board of Health in January, 1877, by a written communication, I called its attention to the large number of opium-eaters in the vicinity of North Lansing, giving many particulars relating to the opium habit as it exists here. In complying with the request of the Board to prepare an article for publication, I have extended the investigation to other parts of the State, the result of which investigation is here given.

"Those best acquainted with its extent are the physician and druggist. As a rule, the physician, although originally responsible for many of the cases in his vicinity, is only aware of them through his business relation with the druggist. The latter, from whom the drug is obtained, from the fear of loss of trade, or, as some of them term it, a violation of confidential business, are often unwilling to furnish any information with regard to it.

"From the supposed impossibility of getting reliable information of the numbers in the larger cities, no circulars were sent to Detroit, Grand Rapids or East Saginaw; and probably from this cause no answers were received from many of the larger cities of the State where circulars were sent.

"The total number of opium eaters reported in the places given is 1,313; of these 803 are females and 510 are males. . . . The population of the cities and villages including the townships in which they are situated, according to the State census of 1874, was 225,633. The population of the whole State at the same time was 1,334,031. If the number of opium eaters, including morphine eaters, in proportion to the population in the places given holds good for the entire State, the total number of opium eaters, all classes, in the State would be 7,763. Taking every degree of the habit into consideration, this estimate of the number is probably not too large.

"The opium-habit in this country seems to arise from many different causes, prominent among which is the indiscriminate use of medicines without intelligent medical advice. Few families are to be found who are without their stock of remedies. Common among these are opium, morphine, Dover's powder, laudanum, and paregoric, besides the domestic prescriptions containing opium. For the nursery, in addition to the common opiate preparations, are the patent soothing-syrups, cordials and anodynes, nearly all containing opium.

"To show to what an extent the dosing of infants with opiates is carried, it is claimed that over three-quarters of a million of bottles of Mrs. Winslow's soothing-syrup are sold annually in the United States. According to an analysis made and reported in the *California Medical Gazette*, each bottle of this syrup contains from one-half a grain to one grain of morphine. Placing the average at three-quarters of a grain to each bottle, the amount of morphine used in this manner would be 562,500 grains, or about 1,171 Troy ounces —enough to kill a half million of infants not accustomed to its use.

"From the predisposition to nervous and neuralgic affections produced by it, probably many cases of opium-habit in the adult have their first cause in the use of opiates in infancy and childhood. A want is created in the child which is satisfied in the adult when opium is taken, tolerance being already established.

"The most frequent cause of the opium-habit in females is the taking of opiates to relieve painful menstruation and diseases of the female organs of generation. The frequency of these diseases in part accounts for the excess of female opium-eaters over males.

"Undoubtedly, in many instances, physicians are directly responsible for the habit, in continuing the medicine too long, or too frequently resorting to it; but more often the opiate is prescribed and afterward indefinitely continued without the physician's knowledge or consent. The prescription intended for a day is repeated by the druggist many times, and its use is continued until the habit is formed. I believe there is no effectual law to reach these cases or prevent the sale of opium in any quantity. At present, it would not be difficult for a lunatic or a child to obtain at the drug stores all the opium he called for, provided he told a plausible story and had the money to pay for it."

For the period of July 1, 1925 to June 30, 1926, a study was made and its results published: *Report on The Legal Use of Narcotics in Detroit, Michigan and Environs*, New York, 1931. The report was ad-

†*The Opium Problem*, by Charles E. Terry, M.D., and Mildred Pellens, Haddon Craftsmen, New York, 1928. It is noteworthy here, also, that to Michigan goes credit for the earliest survey made in the United States.

dressed to the Bureau of Social Hygiene, 61 Broadway, New York, N. Y. It was part of an effort to decide, through sampling the opium needs of certain areas, the actual amounts for medical and scientific purposes required under all conditions for the continental United States.

The research was conducted by C. E. Terry, M.D., Executive, Mildred Pellens, M.D., Associate Executive, and J. W. Cox, M.D., Field Worker. The records reviewed in Detroit elicited the existence of 511 legally supplied addicts to opium and its derivatives. This was a minimal figure, as some patients received their medicine directly from their attending physicians. Of the latter, no information was attained. In addition, 734 illegally supplied addict patients passed through the Detroit police headquarters during the year. Police estimates of illegally supplied addicted citizens were from 10,000 to 12,000. The Summary recommended that the medical profession take "especial care to meet this situation," adding, "greater emphasis should be placed in medical schools on the dangers of addiction formation." The study indicated the desirability of continuing inquiries relating to the therapeutic use of drugs as a part of a program for preventing and controlling addiction.

In the early nineteen-thirties, under the supervision of the Narcotic Educational Association of Michigan, Inc., a farm for local treatment of the narcotic addicted person was maintained at Capac, Michigan. Reverend E. J. Rollings, member of our Mayor's Committee and Dr. Thomas J. Heldt, esteemed Detroit psychiatrist, participated in this movement. Their experience demonstrated that the operation of an institution for the treatment of the narcotic addicted citizen requires special skills, steadfast devotion, constant application, and closely supervised organization. The Capac farm was a noble experiment. It continued for a period of three or four years and was definitely of acknowledged helpfulness. "God helps them who help themselves" is a proverb in all languages. Aeschylus said it, "God loves to help him who strives to help himself." Self-help was a powerful principle of this project. What each Capac patient lacked most, but also needed most, to help himself was his enforced abstinence from intoxication.

Twenty-three years ago, a Survey Committee studied narcotic addiction in Detroit, particularly from the standpoint of its contributing to petty larceny.** The Foreword by Lent D. Upson, stated:

"The merchants of Detroit, like the merchants of most large American cities, suffer large annual losses as a consequence of the activities of kleptomaniacs, of petty larcenists who steal goods for personal use, and particularly of drug addicts who steal articles for resale in order to purchase the means of satisfying their addiction. This last group, known to the police as 'hop heads,' 'dopes,' or 'junkers,' is believed to account for the largest losses—due to continuous activities, the resale of stolen property to 'fences' at a fraction of its value, and to the consummate skill with which the thievery is carried out.

"This study of narcotic addiction as a factor in predatory crime, particularly petty larceny, was undertaken at the instance of the Retail Merchants Association of the Detroit Board of Commerce and a Joint Narcotic Committee appointed by the Wayne County Medical Society, to learn, if possible, something further concerning the number of addicts, the character, extent and cost of their drug consumption, the nature and amounts of their thieving, to which might be appended recommendations for curtailing the resulting loss to Detroit merchants and others.

"The Survey Committee consisted of:

Clarence H. Eisman, M.D., Wayne County Medical Society, Chairman of the Committee.
Charles E. Boyd, Retail Merchants Association, Secretary of Committee.
Ray S. Dixon, formerly Social Hygiene Director, Department of Health.
Percival Dodge, Secretary, Detroit Community Fund.
Don W. Gudakunst, M.D., Deputy Commissioner, Department of Public Health.
Ora Montgomery, formerly Secretary, Detroit Association of Credit Men.
John P. O'Hara, President, Board of Commissioners, Detroit House of Correction.
Lent D. Upson, Director, Detroit Bureau of Governmental Research and the School of Public Affairs and Social Work of Wayne University.

"To finance this experimental study in an area exceedingly difficult of exploration and in which little or nothing is known, an initial grant of $500 was made by the Detroit Community Fund to the Detroit Bureau of Governmental Research, which fund was supplemented from the Bureau budget, and under whose auspices and general direction the survey was made."

This report indicated the great difficulties in estimating the number of addicts illegally supplied with drugs in Detroit. Estimates ranged from 1,000 to 12,000, "with the top figure probably a casual exaggeration." Report No. 9 used the figure of 500 as the basis of its calculations. It concluded that the

**Report No. 9 of The School of Public Affairs and Social Work of Wayne University, entitled, "Narcotic Addiction as a Factor in Petty Larceny in Detroit," by Edward C. Jandy, Assistant Professor of Sociology, Wayne University, and Maurice Floch, Psychologist, Detroit House of Correction, November, 1937.

narcotic addict's "depredations upon community merchants result in large annual losses to them; his larcenies provide extra strain on law enforcement agencies, courts and penal institutions."

Of Report No. 9, the Narcotic Committee of the Wayne County Medical Society, June 8, 1938, reported, "It is an excellently done, thorough piece of research of its kind and conveys a good deal of information to the medical profession and to those who are interested in this problem and . . . it shows many signs of careful, painstaking work on the part of its two authors."

After further comment, including mention of certain necessary shortcomings in such a limited study, the Committee report added, "It is true that some provision should be made by which an offender who is addicted to the use of habit forming drugs could be hospitalized." It summarized, and please note that this summary has its value for today's needs, too:

"Your committee recommends that a hospital be set up that can take care of some one hundred to two hundred drug addicts and perhaps an equal number of alcoholics each year. They must be committed and not accepted as voluntary patients and your Committee would further recommend that some sort of a clinic be provided not particularly for drug addicts but where drug addicts would go among other mental patients for advice and help and, if need be, to pave the way for commitment for actual psychotherapeutic treatment and cure. Your committee would emphasize the need of social service treatment, adjustment occupationally and economically, and also some supervision after release inasmuch as a cure is not accomplished by mere hospitalization."

All help is self-help, but a narcotic addict patient specifically needs to help himself by having himself restrained. After he has detoxified himself, there is a clear possibility that, with sufficient community understanding and practicality, he can continue to help himself outside of a hospital. The duration of his hospitalization, of the kind I shall describe, is an individual problem varying from two or three to six or eight weeks.† The duration of his out-patient treatment is also an individual matter, but would seldom, if ever, be less than one year.

On March 12, 1951, Mayor Albert E. Cobo saw fit to establish the Mayor's Committee for the Rehabilitation of Narcotic Addicts. Every member has taken satisfaction in seeing to it that his is a hard-working committee. Although this committee has made great progress, from time to time one of its members understandably becomes dissatisfied with its rate of progress and, instead of using that dissatisfaction as a motivation for greater effort, is strongly tempted to discontinue his committee effort entirely. The committee member's civic spirit and high-minded morale are outstanding and consistently win out. From the start, the whole committee has operated with three sub-committees: legislation and law enforcement, diagnosis and therapy, and education and research.‡

Mayor Louis C. Miriani, thoroughly familiar with the intent and work of this committee, from its beginning, has seen to its uninterrupted continuation, and has made every effort to advance its cause of educationally furthering prevention and treatment. Mayor Miriani's finely conceived and practically administered Austerity Program allows for his high-minded recognition of his fellow citizen whose soul cries out to be rescued from the snares of self-imposed intoxication.

On January 30, 1953, the whole committee submitted a carefully and caringly prepared report of 172 pages. This publication included twenty-four specific recommendations. Compiled and written up by the committee's executive secretary, Mr. Donald M. D. Thurber, this publication proved helpful nationally and internationally. Unfortunately, the edition consisted of only 1,000 copies which soon ran out. This statement occurred in it:

"The symptoms of disease have profound health significance for the specialist who has grown to see them even as cheering signs showing the way into, and therefore out of, human trouble. Our unprepared fellow man, however, cannot see these abnormalities with the healthy encouragement and hopefulness inherent in the doctor-patient attitude, so that his morale is not strengthened by accounts of painful living. Indiscriminate publicizing of human suffering, although intended to alleviate it, may add to the sum of human misery. The few detailed descriptions of illness in this report have been included by majority rule of our Committee. May any appearance of fault-finding in the report be relieved by the health-affirming insight of deepest appreciation for the indispensable directions to human welfare provided by the signs and symptoms of disease."

Through the work of the Committee, it was possible to establish an out-patient narcotics clinic in the Detroit Department of Health.* Other accomplished objectives it helped to secure were expansion of our Detroit Police Department Narcotics Bureau, legislative changes facilitating compulsory hospitalization of the narcotic addicted person, and augmented educational programs in schools, churches, and other community agencies. It has steadfastly urged the establishment of a *local* in-patient compulsory treat-

†Chronic severe illnesses require much longer in-patient treatment.

‡Respective sub-committee chairmen are Rev. E. J. Rollings, Dr. Thomas A. Petty, and Mrs. William G. Koerber.

*Director, Dr. William J. Wertz.

ment center combined with *local* follow-up out-patient compulsory care. These two projects, the details of which were arranged by committee member, Dr. Herbert A. Raskin, have been found useful not only for national, but also for international, planning purposes. Every member of the committee has felt the need for the continuation of its work in vigilant research and persevering education.

Our Mayor's Committee has received the finest kind of cooperation from every city department and particularly from those with whom it has had to do the most study: members of the Board of Education, the Public Health Department, and the Police Department.** A similar kind of fine cooperation has been forthcoming from our legislators and from our court judges.

> "Separatism . . . is the abstraction of a negation, the shadow of a shadow."
>
> AMIEL

Although narcotism is strictly a disorder of health, as a rule, it does also involve illegal usage. Hence, it is *essential* that physician, judge, attorney, legislator, and police officer undergo the study and research necessary to make sure that the proper focus upon the narcotist is that of *a patient suffering from a serious illness.* With this orientation, everyone is in the best position to be helpful.

Experiences in our Detroit Narcotics Out-Patient Clinic bear out the findings of all physicians that it is necessary for *every* citizen to avoid non-medical narcotization. No one is regarded as sickness proof. Proper health precautions require that every patient have his physician prescribe any and every kind of drug of intoxicating properties. Both the chemical structure of the medicine and the psychological structure of the patient contribute to this addictedness. Morphinism, opiumism, and every other kind of narcotism, refer to a person suffering disordered health. Said Thomas Jefferson, "The God who gave us life gave us liberty at the same time." Liberty and addiction are incompatible.

Sometimes the declaration is made thus, "Physicians have been known to continue successful practices while actively addicted." Such assertions may be most misleading. Everyone, physician or patient, is undergoing a serious health struggle involving the very essence of his appreciation of life itself, as long as he is dependent upon narcotization for the conduct of his life. Healthful self-esteem and dependency upon a drug for making life seem livable, are not the same formula for successful living.§

At the present time, our Mayor's Committee, to the member, has reached the following realization. For the adequate treatment of the Detroit citizen who is suffering from narcotic addiction, there is needed a local in-patient highly specialized kind of compulsory treatment combining psychiatric with general therapy. In addition to this strictly local in-patient care, there is needed a very active follow-up local out-patient type of compulsory treatment.

It is important to note right here that "compulsory treatment" is no exception to the truth that all help is self-help. A person who consciously persists in refusing to treat himself, is unconsciously requiring that he have himself rescued from this suicidal attitude. A sick person of this degree of self-disesteem must be cared for as if he were only a baby. One does not demand that a baby be able to declare his intention to take proper care of himself. The addicted individual, like the lost sheep, needs to be sought for and needs to live passively his returning himself to the fold. These are legitimate medical needs. He is already suffering hurt feelings of segregation and needs convincing experiences that his family and community really belong to him. It is most essential that every patient be able to force upon himself the opportunity of medical supervision by his personal physician, not only during his hospital stay but also throughout the time of his effort at adjusting himself for the living of his community and for the resumption of his occupation. In addition, members of his family, as well as certain members of his greater community, need definitely and critically to have opportunity for developing the kind of understanding which will make it possible for each of these individuals to behave usefully, instead of harmfully, while the patient is attempting his rehabilitation. Over the years, experience has indicated beyond any doubt that an addict patient, in every instance, is an emergency case deserving medical treatment not only *when he needs it,* but also *where he needs it.*

The United States Public Health Service, through its National Institute of Mental Health, has expressed a willingness to subsidize, for the most part, the establishment of the kind of in-patient and out-patient treatment unit described, *provided that local funds also contribute to the project.* The federal subsidy would

**Special mention is due Inspector Russell J. McCarty in charge of Detroit's Police Department Narcotic Bureau, Mr. Ross Ellis of the Federal Narcotics Bureau, and Mr. Ernest F. Rossi (now deceased), each of whom has devoted himself without stint to furthering the Committee's effectiveness.

§Professor Walter H. Seegers, Chairman of the Department of Physiology and Pharmacology, Wayne State University College of Medicine—personal communication.

amount to approximately $200,000 a year; the local investment in community health would approximate $60,000 a year. This facility would treat 200 addicted citizens a year. Sufficient space for this clinic has been made available by the Detroit Department of Health. Federal Commissioner of Narcotics H. J. Anslinger regards this solution as being an extremely worthy project which has his unqualified approval and support. He realizes keenly that without provisions for local treatment of Detroit's addicted citizens, the problem of enforcing the narcotic laws here must continue to be a tremendous one. In his view there should be established in Detroit, as soon as possible, this adequate treatment center providing facilities for physical withdrawal, intensive psychiatric treatment, a follow-up program for at least two years, and continuing health education aimed specifically at drug addiction prevention.

Every member of our Mayor's Committee is now interested in mobilizing Detroit's civic spirit to deal realistically with our critical public health problem of drug addiction. Health-conscious men and women workers of every kind, including doctors, lawyers, educators, ministers, editors, lecturers, and particularly every elected and appointed public servant, each one needs to educate himself about his Detroit drug addiction seriousness and its implications for every possible part of community living.

The development of the *practical* kind of required local in-patient and out-patient general and psychiatric treatment just described, brings *medical realism* into the picture of narcotics addiction. A narcotic addicted citizen would rather not consider himself as ill, particularly as mentally ill, which he certainly is. Similarly, the "drug peddler" would not like to consider himself as the madman, which he grievously is. As long as this *medical realism* herein described is not applied to the treatment of the condition, it will be possible for the organized "dope peddler" to go on regarding Detroit as a likely target for his aim. On the other hand, if the so-called "pusher" requires himself to face the *medical reality* of having himself diagnosed a psychiatric patient requiring psychiatric treatment over an indefinite period of time, this kind of reality orientation would be his chief deterrent, the one deterrent which is now sadly lacking in force.

James Clayton presents convincing statistics* to show the immense advantage of psychiatric hospital treatment over incarceration for the "criminal's" enlightened care. As an offering to any critic who regards Judge David L. Bazelon's renowned Durham case rule ("acquittal by reason of insanity must result if the crime was a product of mental disease or defect") as being "an easy way out" of responsibility, author Clayton concludes, not without humor, "Almost anyone in his right mind would prefer a term in prison to a term in a mental hospital."

"Thank God for the iron in the blood of our fathers."
THEODORE ROOSEVELT

In conclusion, what is direfully needed is a realistic appraisal of the awful health disorder known as "drug addiction," so that medical responsibility and authority can apply itself freely. The illness is of disaster proportions right here in Detroit, and it is the proper concern of every public-spirited person. Education upon the topic, Detroit's Drug Addiction Endemic, is a needed sign of the aroused spirit of Detroit, ever-ready to build itself out of its ashes. First things first, the rescue of our despairing fellow citizen from his slavery to his habit is a Detroit First. Effective education of the individual citizen, by himself, is a necessary initial step. He must first see clearly that he goes to bed with this horrible treason at night and gets up with it in the morning; then, outraged, he will begin to demand in the name of his vitalized patriotism that realistic measures be found and instituted to deliver him from this evil. First of all then education, and continuing education. Said Socrates, "One only evil, namely, ignorance."

Lastly, every instance of drug addiction involves a unique individual whose prognosis for curing himself, in my opinion, is 100 per cent favorable, provided that his treatment is sufficiently realistic. The necessary prolonged duration of the treatment; the necessary relapses which are par for the course of that treatment; the necessary irregularly recurring discouragement, hopelessness and inability to cooperate on the patient's part; the necessary impatience and refusal of the patient's relatives to put up any longer with his "back-sliding"; the necessary frustration of the physician's own therapeutic pride and ambition; the necessary dissatisfactions and resentments of the medical doctor's colleagues who are less experienced for understanding this difficult professional study and practice; and, perhaps, above all, the necessary mental preoccupation of each patient with "externals," with his materialistic ideas of helpfulness to the corresponding exclusion of his self-insight; each of these, as well as other medical necessities, is considered part of the day's work by the physician adequately prepared to diagnose and treat addiction disease.

*"Six Years After Durham," *Journal of the American Judicature Society*, June, 1960.

The Surgery of Deafness

I. Myringoplasty by Bi-Pedicle Flap Vein Graft Technique

Brian F. McCabe, M.D.
Ann Arbor, Michigan

IN RECENT YEARS there has occurred a resurgence of interest in the rehabilitation of the patient afflicted by a conductive deafness, the result of active or inactive suppurative disease. This re-interest has brought about a renaissance in otologic surgery, occasioned at least in part by advances in knowledge of acoustic physiology and its dissemination to otologic surgeons, by the availability of better light, better visualization and better training, and by the painstaking development of new surgical techniques based upon sound physiologic and surgical principles.

A common ear disorder resulting in the restriction of the patient from some sports and also his exclusion from certain occupations is the perforated tympanic membrane. The type of perforation amenable to closure by simple techniques is the central perforation with an undiseased middle ear. If active chronic suppuration is present, simple closure will fail and must be accompanied or preceded by mastoidectomy to eliminate osteitic bone and cholesteatoma when this is the source of the suppuration.

The symptoms of an uncomplicated tympanic perforation are usually only that of a mild deafness and its sequela, tinnitus. The deafness is conductive in nature, with prolonged bone conduction (plus-minus to negative Rinne), and lateralization of tuning forks to that side. When the deafness is greater than 30 decibels (a medium whispered voice at the ear) it is not due solely to the tympanic perforation, and attention must be directed to the entire aural mechanism to determine the cause. The tinnitus is mild and usually of the rushing wind or waterfall variety although frequently none is present. Often there is a history of brief mucoid otorrhea with upper respiratory infections.

The Author

BRIAN F. McCABE

M.D.

Physicians have attempted the closure of perforations for at least a hundred years.[1] Initial attempts involved the employment of animal membranes such as goat conjunctiva and pig bladder; later innovators advocated prepared tissues such as dried amnion, and prosthetic devices including cigarette paper, Koroseal, Korogel, polyethylene, cotton, silastic, and siliconized paper. The disadvantages of prostheses center around their temporal nature. As early as 1876, cautery of the perforation margin was found to promote proliferation until the margins of the perforation met.[2] Silver nitrate was the first agent used for this purpose; now, trichloracetic acid is used almost exclusively.[3] When this method yields success, it is superior to any other method because the gap is then bridged with tissue appropriate to that area, tympanic membrane, which is morphologically unlike any other organ in the body in its thinness, toughness, and acoustic properties. The difficulties here are several, chief among them that not all perforations can be closed by cautery.[4] Weekly cauteries are necessary, requiring in our experience from four to sixty-two visits, with an average of twenty. For the patient to maintain a schedule of weekly visits for longer than four or five months requires more than an ordinary amount of determination. If the patient comes from some distance, as is often the case in my office, this is not a very practical method. A modification of it is used, however, with 95 per cent success, requiring only one treatment. The perforation rim is cauterized in the usual manner and covered with a dried sterile amnion patch, moistened with neomycin solution just before

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EDITOR'S NOTE: This is the first of a series of four articles on The Surgery of Deafness. The other articles will appear in future issues of THE JOURNAL.

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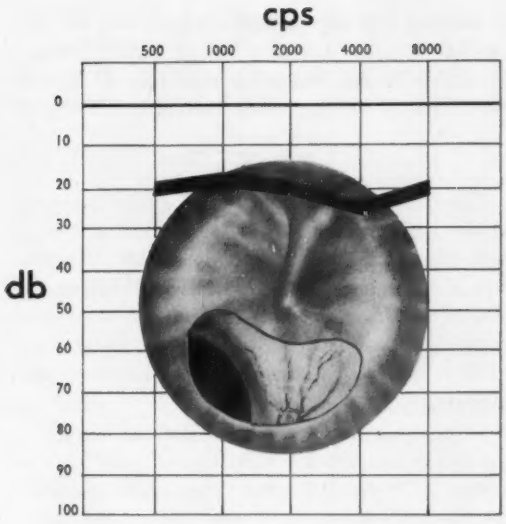

Fig. 1A.

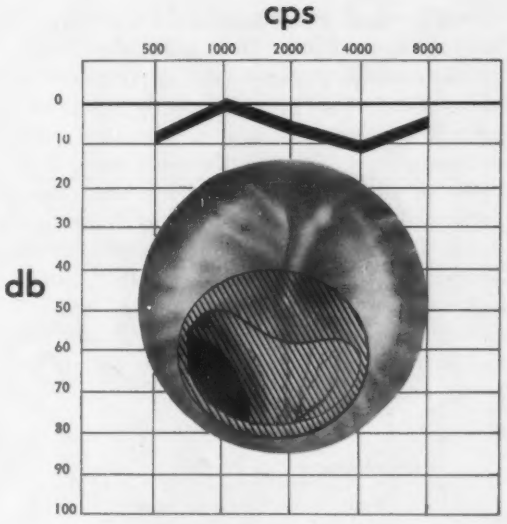

Fig. 1B.

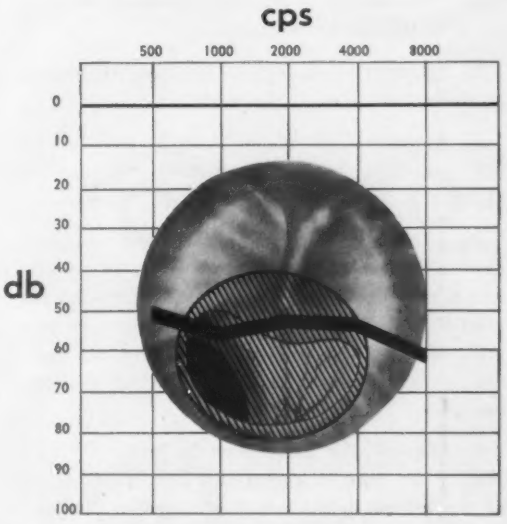

Fig. 1C.

Fig. 1. Patch testing of the middle ear is a simple and effective method of determining the continuity of the ossicular chain. An audiogram is obtained prior to patch testing. In the following case (A), the hearing level is 20 decibels decreased. A tissue paper or plastic film patch is then applied to the tympanic membrane (B). If the hearing level then rises, the ossicular chain may be assumed to be intact. If, however, the hearing level is thereby dropped below its original level, the ossicular chain is disrupted: (C). In this event, ossicular chain continuity must be restored prior to myringoplasty.

application. This has been described by Schrimpf.[8] Patients must be selected carefully, having an entirely central perforation not over 2 mm. in diameter.

The first surgical closure of a tympanic perforation was performed probably by Berthold in 1878, who coined the term "myringoplasty." He was the first to utilize a full-thickness, free skin graft with success, but the method fell into disuse until revived recently by Wullstein[6] and also by Zollner. The outer surface of the tympanic membrane is de-epithelialized and a tailored full-thickness skin graft placed which depends for survival upon an intracapillary circulation. This technique attains a significantly high success rate but it, too, is attended by disadvantages. First, the graft never quite attains the thinness of the natural tympanic membrane. Second, it may not be suitable for extremely wide perforations because the wider the perforation the higher is the rate of graft perforation.[7] Third, graft and canal cholesteatomas can occur years later when the patient may be lost to follow-up.[5] Fourth, for some inexplicable reason, many full-thickness grafts in the ear continue to desquamate heavy layers of moist keratin for months or years.

A method of closure satisfactory for very wide perforations has been evolved which combines several proven techniques. This method employs a viable bi-pedicle full-thickness skin flap from the canal wall and a free vein graft to bridge the remaining gap. Sooy described a somewhat similar technique suitable for smaller perforations utilizing a uni-pedicle flap.[9]

The use of vein as a graft material has been described by Shea and by Tabb.[10] A bi-pedicle flap has the obvious advantage of better blood supply to the advanced tissue. Vein, in the closure of perforations, probably acts as a scaffolding in a manner similar to cigarette paper or amnion, but would appear to be a superior material in that it obtains a blood supply and becomes a living scaffold until its job is done, and then is largely resorbed, leaving regenerated tympanic membrane in its place. Further, it is likely that at least the intimal and subintimal layers of vein wall are accustomed to a low oxygen tension and may tend to survive longer than dermis in the event a prompt intracapillary circulation is not set up.

Requirements for Bi-pedicle Flap Vein Graft Myringoplasty

1. The middle ear must have been absolutely dry to the surgeon's inspection for at least three months. Merely the absence of subjective discharge from the ear is inadequate investigation.

2. Evidences of active osteitis, bone destruction, or cholesteatoma must be absent.

3. A functional eustachian tube by Valsalva, Politzerization, or tubal catheterization test must be present.

4. An anterior rim of tympanic membrane sufficient to be visible is probably necessary. A posterior rim is not necessary; the perforation may be marginal here. In this case, the surgeon must be especially meticulous in the second stage of the operation to exclude the presence of a lurking cholesteatoma.

5. The ossicular chain must be intact, or reparable at the time of operation. This is the subject of the second in this series of articles. Briefly, it may be said that if the hearing loss is no greater than 30 db and the hypotympanum is open to the mesotympanum, the ossicular chain is probably intact. Patch testing is a simple and effective method of testing and has the additional advantage of dramatically demonstrating to the patient the rise in hearing. If the patch increases hearing, the chain is intact. If the patch decreases hearing the chain is disrupted. I find that siliconized tissue paper of the kind used for polishing glasses makes an excellent patch material. Pre-cut discs of different sizes can be kept at hand. The disc is moistened on one surface with an ear drop or ointment and may be facilely placed over the perforation with the use of a middle ear suction tip. Very large or marginal perforations cannot be patch tested because the information derived is not reliable.

Technique

The operation is performed under sterile conditions in the operating room. The canal, auricle, and adjacent skin is scrubbed with phisohex and the canal aspirated. Then the canal is filled with Betadyne and allowed to remain for ten minutes while draping is carried out and instruments arranged. Local anesthetic is used in the usual manner as for stapes mobilization.

1. The first step is debridement of the margin of the perforation to break the mucocutaneous bond at the margin of the perforation. This is best done while the tympanic membrane is tense, before flap elevation. Care must be exercised to remove that skin on the immediate inner margin of the edge; the skin grows over the edge to meet the non-advancing mucosal layer in rendering the perforation permanent. Atrophic areas of tympanic membrane without a fibrous middle layer are removed at the same time because these areas are without blood supply and participate poorly in healing. Special 90°, 45°, and 30° fine middle ear cupped forceps are used for this purpose.

2. A full-length posterior bony canal flap is then raised. The incisions form three sides of a rectangle, the two axial incisions each being slightly forward of the usual stapes mobilization flap and 1.5 mm. short of the annular rim, and the circumferential incision being just inside the verge of the bony canal. Elevation is carried out to the annulus and for a short distance anterior to proximal ends of the axial incisions. The annular ligament is elevated from its sulcus thus rendering the 1.5 mm. superior and inferior pedicles mobilized. The outer flap and posterior three-fifths of the tympanic membrane will depend for blood supply upon these tiny pedicles. It may seem incredible that this relatively large tissue mass can survive with ease with such narrow pedicles, but I have not seen an instance of flap or membrane necrosis. It is self-evident that other factors besides pedicle blood supply are operative here, probably among them are high diffusion penetrability in flaps of very small size, the optimum temperature and humidity of the depths of an orifice, and the immobility afforded by a bony chamber. The ossicular chain may now be inspected and the aditus examined for latent disease.

3. The canal flap is then advanced down the posterior canal wall which at the same time advances the posterior margin of the perforation anteriorly. If the perforation is relatively small the two edges may thus be brought together in slit-fashion and the approximated edges splinted with gelatin sponge. If the perforation is large, the posterior edge can be advanced past the handle of the malleus by dissecting the upper crescent of tympanic membrane off this ossicle which is a simple maneuver after the mucosa over the posterior face of the handle has been slit.

4. When the flap has been advanced to the limits of pedicle flexibility, which should close the perforation by no less than two-thirds, the remainder of the dehiscence is bridged with a free vein graft. The vein in area should be no less than twice the area to be bridged. If a large dorsal hand vein is not available, a segment of external jugular vein is used. Gelatin sponge discs, 5 mm. in diameter, are layered in the tympanum in rouleau-fashion, the tympanum is flooded with neomycin solution, and the advanced edge of the perforation brought to rest on the tym-

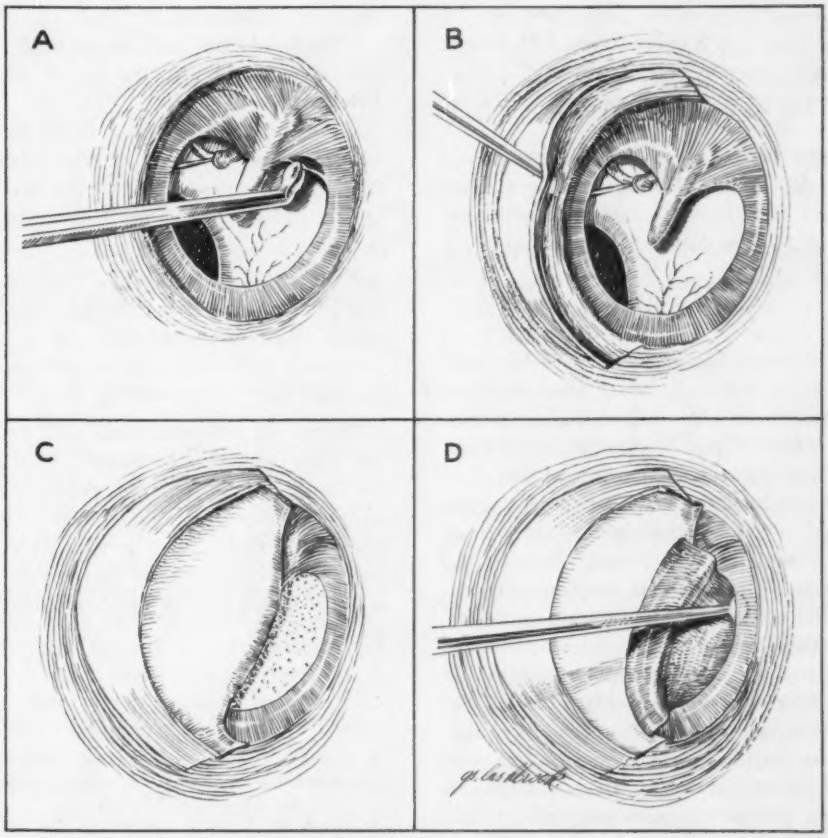

Fig. 2. Technique of bi-pedicle flap vein graft myringoplasty. The margins of the perforations are debrided (a) to break the mucocutaneous bond. Special forcepts angulated at 30,° 45°, and 90° are used for this purpose. A posterior canal flap (b) is elevated the full length of the bony canal from 5 o'clock to 1 o'clock with the axial incisions stopping 1.5 mm short of the annular ligament. These 1.5 mm pedicles will nourish the flap. With flap and pedicles mobilized, the flap is then slid down the canal wall (c) thus advancing the posterior margin of the perforation forward. A buttress of gelfoam discs in the tympanum holds the edges of the perforation in the same plane. If the perforation is not thus closed, a rectangular segment of vein is then tucked inside the edges of the perforation (d) all around to bridge the remaining gap.

panic buttress of gelatin sponge. The vein graft, intima-inward is then placed by tucking its edges underneath the perforation edges. As the gelatin swells, the vein is held securely in place against the inner aspect of the tympanic membrane. Increased blood supply will be afforded the graft if just prior to placement the mucosal layer at the perforation edges is scored many times with a sharp acutely angled hook. This frequently removes irregular shreds of epithelium, providing a wider area of contact between the fibrous layers of the two structures.

5. The outer surface of the composite is splinted with moist gelatin sponge discs, terminating the procedure. These outer discs are kept moist with antibiotic solution and not disturbed for four weeks.

Results

This procedure has been instrumental in my hands in the closure of nine perforations which may not have been closable by other methods because of their size. Four of these performations represented approximately four-fifths the total drumhead area. Each closure was attended by a rise in hearing in the patient. The improvements ranged from 10 db to 30 db and each was notable to the patient. Even the patient with a 10 db gain claimed significant improvement. All had relief of the hollow, stuffy, or "dead" feeling on that side of the head. Each ear has remained dry and without desquamation, and has required no aftercare subsequent to initial healing. The average stay in the hospital has been forty-eight hours, and the usual number of office visits five, over a six-month period. In two of the very large perforations, the patients operated upon subsequently suffered a delayed re-perforation, each in the area of the vein graft, but these were now small enough to be patched with silastic film until re-operation was convenient, with no interim limitations to the patient except restriction from high diving and skin diving which neither patient minded because neither cared for these sports.

Advantages

1. Large perforations can be closed in this manner with a better chance of success because the size of the free graft can be rendered materially smaller.

2. Perforations of a marginal nature posteriorly are amendable to closure by this method since a new posterior margin is created by the advancing flap.

3. Many dangers attendent upon closure of a posterior marginal perforation or any perforation are eliminated because upon elevation of the flap it is a simple and routine maneuver to remove enough annular bone to inspect the lower part of the ossicular chain for partial disruption and the aditus ad antrum for latent cholesteatoma.

4. Perforations of moderate or small size can frequently be closed with the use of the sliding bi-pedicle flap alone.

5. The canal skin is used to bridge the majority of the perforation. This material attains a thinness greater than any other cutaneum because it is already extremely thin, and has thus proportionately better acoustic properties.

6. With the exposure attained, it is possible to simultaneously repair a disrupted ossicular chain.

Summary

The use of a bi-pedicle full thickness canal flap and a vein graft may be attended by a high success rate in the closure of tympanic perforations. For many perforations it seems superior to any other method, especially for large and marginal perforations. No other method of closure gives the surgeon as much control over the auditory conductive apparatus as a whole.

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Homosexuality

A Medico-Legal Problem

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THE LAWS of Michigan and of most of the states reflect the ignorance and the superstitions of well-meaning legislators of 100 years ago. The rules and regulations governing traffic naturally had to change with the development of the automobile and the highways; regulations for aircraft are constantly being altered; public health measures show only a slight lag between scientific discoveries and legal readjustments.

Yet the laws concerning homosexuals have stayed far behind advances in the field of psychiatry and the field of education. Uninformed people express their fears and prejudices, and "act out" their own perfectly natural inhibitions against perverse sexual behavior; hence, such topics are laden with emotion, and no public figure wants to be associated with such topics, even if he be well-informed, because it is painful to challenge the prejudices of people. As a result, the judges, prosecuting attorneys, and lawyers are "on the spot" to enforce laws that go back to primitive attitudes, yet obviously are not in line with modern humane concepts and knowledge. The person with homosexual behavior—a maldevelopment of personality structure —is humiliated, an otherwise constructive career often wrecked, and society robbed of millions of dollars in police costs and loss of services of the convicted homosexual. It is high time that the public learn to tolerate the topic, to examine the facts and the most widely accepted theories, and to back a revision of the archaic laws. There need be no "cultural lag" in legislation, if we are willing to think through these issues and give moral support to the lawyers who are already preparing model codes in these areas.[3] Our own State of Michigan's report[4] of the Governor's Study Commission on the Deviated Criminal Sexual Offender is now ten years old and should be on the reading list of every serious citizen concerned with the persecution of otherwise law-abiding citizens.

Sources of Information

Reference has already been made to several recent publications, but it should be emphasized that numerous popular and technical studies are available, and indicate the concern shown by workers in diverse fields. Perhaps one of the best and most unimpeachable sources of especial interest to legislators, judges, prosecuting attorneys and lawyers, is the *Model Penal Code* constantly being reworked by the American Law Institute. The research abstracted by these men covers psychiatric literature, police statitistics, and many other sources of information and informed opinion. The recently published *American Handbook of Psychiatry* gives excellent coverage of the psychodynamics of sexual perversions, plus information on community problems and legal regulations. The Kinsey reports give us a view of the widespread nature of the problems, including statistics which indicate that half the adult population probably has experienced at least one homosexual relationship since childhood (which may explain why we have to act naïve about the problem). The psychiatric journals contain many articles of more technical nature, and Drs. Berg and Allen have devoted an entire book to *The Problem of Homosexuality*, including their analysis of the Wolfenden Report prepared in England in 1957.

Before going into a listing of recommendations and a discussion of what might be done, a few remarks can be directed to our own consciences. If we accept the prevalent understanding that the homosexual is

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A statement from a study by the Mental Health Committee of Washtenaw County Medical Society. Dr. Mason is chairman of the committee.

The Council of the Michigan Society of Neurology and Psychiatry and the Michigan District Branch of the American Psychiatric Association gave their unqualified endorsement of this statement on September 29, 1960.

the hapless victim of a maldevelopment of personality structure, it follows that we must provide maximal opportunities for his readaptation. This is no plea to absolve the homosexual from any moral responsibility; it is a plea only to define his responsibility. A patient with tuberculosis has a responsibility to society *because* of his disease, but certainly does not merit legal and social annihilation. A person with normal heterosexual desires is morally obligated to discharge his sexual tensions in appropriate ways. A homosexual who discharges his tensions is similarly obligated to do so in ways which are harmless to others. Then, we must ask, what "living space" and what regulation is right for the homosexual? Are homosexuals dangerous? When? Are they "bad" people? Do they have any rights? How clearly does society face the fact that at present they are branded, despised, blackmailed, and persecuted? Would "a liberal attitude" and "tolerance" lead to an increase in the incidence of homosexuality, or of crimes associated in the public mind with homosexual fixation?

New Concepts

We cannot answer all the questions we have raised, but we can express in condensed form the modern views of people working in allied areas. An important starting point is expressed in the views of the Reporters to the Advisory Committee of American Law Institute (Model Penal Code, p. 277 ff), who believe that consensual relations between adults should be excluded from criminal punishment:

> Our proposal to exclude from the criminal law all sexual practices not involving force, adult corruption of minors, or public offense is based on the following grounds. No harm to the secular interests of the community is involved in atypical sex practice in private between consenting adult partners. This area of private morals is the distinctive concern of spiritual authorities. It has been so recognized in a recent report by a group of Anglican clergy. . . .
>
> As in the case of illicit heterosexual relations, existing law is substantially unenforced, and there is no present prospect of real enforcement except against cases of violence, corruption of minors, and public solicitation. Statutes that go beyond that permit capricious selection of a very few cases for prosecution and serve primarily the interest of blackmailers. Existence of the criminal threat probably deters some people from seeking psychiatric or other assistance for their emotional problems; certainly conviction and imprisonment are not conducive to cures. Further, there is the fundamental question of the protection to which every individual is entitled against state interference in his personal affairs when he is not hurting others. . . .

Since perverse sexual practices are symptoms of underlying pathology, a concise answer cannot be given concerning the "dangerousness" of homosexuals as a group. Only by a painstaking and thorough evaluation of each homosexual can the personality problems and potentialities for harm be assessed. But, by and large, overt homosexuals are (otherwise) well-behaved, law-abiding and productive citizens. The shocking "sex crimes" typically involve psychotic, predominantly schizophrenic, individuals who in the process of deterioration may show all sorts of unusual sexual aberrations as they regress through childhood levels of behavior. Such people are not picked up by the usual police techniques of luring overt homosexuals by various forms of solicitation in the public toilets. The very existence of punitive legislation and "vice squads" has exposed otherwise law-abiding citizens to blackmail and criminal attacks (i.e., "rolling"), and public exposure frequently leads to loss of jobs and to suicide. The book by Berg and Allen[3] gives many specific illustrations of these untoward effects of prosecution.

One psychodynamic pattern of behavior should be mentioned here, as of especial concern to the problem of law-enforcement personnel: that is the mechanism of "reaction formation." A child is often shamed into leaving one level of childish behavior in favor of a more mature way of acting, by doing just the opposite of the original bit of behavior. Most mothers, for example, are aware of infants' interest in the process and products of excretion. An undue emotional stress on this behavior may result in a "reaction formation" wherein the child becomes fastidious, "too clean," "clean with a vengeance," and disturbingly tense in situations where dirt and disorder naturally prevail. The fervor to be clean contains in it the energy of the previous inclination to be dirty—and the behavior now contains an *excessively emotional* attitude (instead of a *calm rational* attitude) which interferes with normal life patterns of behavior. Saul, persecuting the Christians prior to his conversion, is perhaps the most popular example of a reaction formation. Analogously, psychiatrists find that many highly promiscuous people, and many who vigorously condemn sexual perversions, are similarly reacting in a highly emotional and unreasonable way to deny—to themselves and to the world—their difficulty in leaving the childhood phase of development that involved "normal" impulses which, if unresolved, lead to homosexual behavior. It is a matter of common observation that the worst condemnations and most vigorous prosecutions of homosexuals involve "vigilantes" of questionable emotional maturity. It is with great wisdom that the Canadian Army regulations require that soldiers caught violating regulations against homo-

sexuality be referred automatically to medical channels for administration and supervision. Berg and Allen[3] (p. 159) state:

> The only proper approach to this problem is knowledge—knowledge of the facts and understanding. Emotional reactions are morbid symptoms whether they manifest themselves in the positive acts of perversions, such as homosexuality, or in the reactive forms of rage and sadistic punishment *against* perversions and homosexuality. Both perversions and emotional reactions against them are symptoms. *Symptoms are not appropriate therapeutic agents, nor are they sound judgment.* (Italics theirs).

Tolerance towards homosexual behavior cannot be considered an inducement to increased homosexuality if modern theories of causation are correct; and, if it develops that the more archaic theories of inborn errors of body chemistry turn out to be correct, this will make even more untenable the idea that tolerance is a factor leading to increased homosexual behavior. Certainly, attempts to make rehabilitation possible must be carried out in an atmosphere of tolerance. Most psychiatrists believe, with experience to support the belief, that the removal of irrational, blind inhibitions in a given patient allows that person spontaneously to experience normal, basically "moral" ways of living, not based on excessive external pressures to behave in a certain way. Analogously, decreasing the stigma on tuberculosis has encouraged victims to seek treatment, has encouraged the research that is leading to the eradication of the disease, and has demonstrated once again that the natural self-interests of most people lead them to seek help when no stigma is attached.

The Role of Psychiatry

Psychiatry has four real, if overlapping, roles to play in the community, as regards the problem of homosexuality. In the first place, some homosexuals can obtain real cures through psychiatric therapy. While this percentage of cures is not high—for a number of reasons—enough homosexuals resolve their conflicts to make psychiatrists feel that our undertstanding of the psychology of these people is correct.

In the second place, psychiatric examination of homosexuals (in a sincerely non-punitive atmosphere) can serve to differentiate the overt, practicing homosexual from the disturbed, psychotic, or psychopathic character who needs some form of continuous or intermittent institutional control. That is, some diagnostic facilities should be brought into play whenever an adult disturbs the community by inappropriate public display of sexual behavior, the molestation of minors, or the use of force or intimidation to achieve sexual gratification.

In the third place, supportive treatment of the related emotional problems of some homosexuals provides them with relief and greater efficiency on the job. It is not unusual for one or both partners in a marriage involving one homosexual member to seek help for certain crises that arise from time to time, indirectly as a result of the homosexual behavior. For example, a female homosexual became extremely depressed on being jilted by her homosexual partner. She sought relief in alcohol, and made a superficial suicidal gesture to make the former partner "feel sorry"—much to the consternation of the husband and her children, who had no comprehension of the situation. Brief, supportive therapy helped to alleviate the family crisis, without in the least altering the homosexual tendencies of this woman.

Finally, the social acceptance of homosexuality as a by-product of civilization will enable psychiatrists and other professional workers to educate the public as more research justifies it, with the ultimate aim of prevention. As Berg and Allen state[3]

> ... The homosexual is not just a man with a wicked or perverse wish to behave differently from others. He is not someone offered the loveliness of women and by sheer cussedness spurning it: he is ill in much the same way as a dwarf is ill—because he has never developed.

Recommendations

For the sake of brevity and clarity, the following succinctly-stated recommendations are suggested:

1. The laws of the state should be changed to conform more closely with the recommendation of the Reporters to the Advisory Committee of the American Law Institute, that all sexual practices not involving force, corruption of minors, or public offence, be excluded from the Criminal Law. More specifically this would mean:

   (a) any legal interference in the sexual activities between two adults, carried on by agreement, in privacy, is an invasion of the basic right of the individual;
   (b) sexual activities involving display distasteful to the public, or exposing children to such displays, should be prevented by law, and violators examined for appropriate corrective action;
   (c) any sexual act between an adult and a child, whether heterosexual or homosexual, should lead to appropriate legal restraint, treatment and/or punishment;
   (d) any sexual act involving force, coercion, or violence, should likewise lead to appropriate legal restraint, treatment and/or punishment.

2. The mental health facilities of the state should be so arranged that

(a) sexual offenders will be examined immediately by psychiatrists employed by the Department of Mental Health or any recognized court-appointed psychiatrist, for medical recommendations (final disposition by court decision);
(b) a program of supervision (analogous to probation) be evolved with the same mental health facilities, in order to provide follow-up protection from and guidance for chronic offenders and potentially anti-social characters;
(c) sexual offenders now incarcerated should be carefully screened by a board of review similar to those in the Armed Forces, with power to recommend to judicial authorities the most reasonable disposition in view of their personality structures and the needs of society;
(d) the plans include some arrangements whereby patients so handled will bear as much of the costs of their treatment and/or supervision as possible.

3. A panel of lawyers and psychiatrists should be established for full consideration of contested decisions—a "supreme court" of qualified legal and medical experts appointed by the Governor or some appropriate legislative body.

These recommendations of the panel have been put down in concise form in the interest of brevity and clarity. This is a complex topic with many ramifications and any action undertaken requires the expert knowledge of many groups, especially the judiciary, the legal profession, people dealing in social services, the penologists, criminologists and all law enforcement agencies. This is a plea for all citizens to look at this problem dispassionately and support constructive legislation for dealing with the problem of homosexuality.

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Some Studies on the Metabolism of Ethanol

An *in vitro* comparative study has been made of the utilization of acetate-1-C^{14} and ethanol-1-C^{14} by way of the citric acid cycle in liver homogenates and isolated liver cells from ethanol-treated and untreated rats. The results demonstrate that acetate is utilized more readily by livers of normal rats than by those of ethanol-treated animals. In contrast, ethanol is better utilized by livers of the treated than by the normal rats. Accordingly, it is suggested that an increased activity of some of the enzymes which lead to the formation of acetyl-CoA from ethanol could be a contributing factor.

Another series of experiments demonstrated that prolonged treatment of rats with alcohol results in a steady rise in the levels of alcohol dehydrogenase (ADH) and to a lesser extent, of acetaldehyde dehydrogenase (ACDH) in the liver, a change which apparently is independent of food consumption. It should be pointed out that the former is considered the rate limiting enzyme in the chain of alcohol oxidation. After the levels of both enzymes attain a maximum, there seems to be a gradual decline probably in proportion to the degree of hepatic damage induced by the continuous intake of alcohol. The withdrawal of ethanol after 20 weeks of administration was followed by a decrease in ADH levels to control values.

This study was further extended to the determination of the activities of ADH in the sera of alcohol-treated rats as well as to those of normal and alcoholic human subjects. An increase in the ADH levels in the alcohol-consuming groups over controls was observed although the absolute values of this enzyme were much less than those in the livers of rats.

Although the above-mentioned findings can at least explain tolerance to ethanol, it is not yet known whether these aberrations are a by-product of alcoholism or are factors actually conducive to the disease. Nonetheless, early withdrawal of alcohol from alcoholic patients before any serious damage has occurred in their livers could reduce the activity of ADH to pre-drinking levels, as was found in the present study on rats. Should future work reveal that the rise in the levels of enzymes, particularly ADH, is implicated in causing alcoholism in man, the present findings could be of great value in the understanding and perhaps the control of this disease.—Abstract of a paper presented by Rashid M. Dajani and James M. Orten, Department of Physiological Chemistry, Wayne State University College of Medicine, Detroit, before the Detroit Physiological Society, December 15, 1960.

Socialized Medicine

Two and three decades ago the profession objected to and fought at every opportunity every move leading toward compulsory health insurance which the bureaucrats advocated but which the medical profession recognized as socialized medicine.

For a number of years now the profession has been opposing what it called the Forand-type legislation under which, as was repeatedly stated during the election campaign and afterwards, that people aged 65 and over would get their medical and hospital care under social security. The bureaucrats and the advocates of these measures, including President Kennedy, insisted this was not socialized medicine. It was compulsory, it used your taxes and mine and those of everybody else who paid taxes to render special services or benefits to a selected group of people. That group was in involuntarily. That is certainly socialism. The Socialist party itself has stated many times this was its ambition, and it could increase these services in extent and amount of coverage and in the eligible age limits. Forand has admitted his Bill would be a foot in the door from which could be built complete compulsory medical care.

Last summer between the nominations and the election, the Congress made an effort to pass the Forand Bill, or one introduced by Senator Kennedy, and it failed. The Republicans proposed bills which met the opposition of the medical profession. However, Senator Kerr went to work with both groups and the Kerr-Mills Bill was evolved, under which the needy among the retired and over 65 citizens (whether under social security or not) could be cared for under certain specific regulations and under general taxes. This is a group of people who in all justice has a claim upon the general population for care and assistance. The beneficiaries of Social Security in the over 65 group, and those being automatically added to that group and granted health services, under the new HR 4222 would create a great tax injustice. Actually the vast majority would be getting benefits they could well pay for themselves and would be foisted upon a service which over the years had built up a special tax fund by compulsory taxation, anticipating benefits for their old age.

The Kerr-Mills Bill which the medical profession advocated was passed and put into effect in Michigan at just about the time of the election. It was anticipated there would be about 65,000 beneficiaries in Michigan.

The Act has been in effect now for four months or more and there have only been 8,300 applicants, just about 1/8 of the estimated number who would need this service. So far as the doctors can see there is no one suffering for lack of service. Of course over 235,000 of the estimated 600,000 persons over 65 are now covered by Blue Cross and Blue Shield. The Kerr-Mills Bill is effectively caring for the aging persons of meager incomes who need attention, as was

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requested by the House of Delegates of the American Medical Association about four or five years ago.

The Kerr-Mills Bill is private, individual medical care with patients selecting their doctors, and this service is paid for by a general tax as has been done for ages for this group, they being the natural responsibility of the general public.

Socialized Power and Light

The bureaucrats and the socially minded politicians are not resting with medicine in another move to introduce socialism into the United States. For many years we have had an example and a very outstanding one. The *Saturday Evening Post*, in its editorial of March 25, says:

"SOCIALISM WOULD BE A STRANGE EXPORT FOR THE U.S.A."

"In announcing the appointment of a new member of the board of the Tennessee Valley Authority, President Kennedy urged that organization to 'study ways in which the lessons it has learned in the Tennessee Valley may be exported abroad.' While few dispute the accomplishments of TVA as an engineering achievement, it would be less than accurate to send abroad the impression that only by tax-consuming, semi-socialistic projects have we taken 'long leaps forward!'"

The editorial comments that TVA has used the taxpayers' money and has accomplished great things but has made no return of taxes to the government. It says private power companies using their own and their stockholders money have made just as elaborate advancements in science while paying taxes. It cites Idaho Power Company, Hell's Canyon dams which paid $10,000,000 in Federal, state and local taxes last year. It wonders why the "capitalistic" United States should attempt to educate other countries on the virtues of socialism.

It is an interesting fact that the private independently owned power plants in Michigan, for instance, while making tremendous advances and helping develop two nuclear fission plants, not only has not used public funds, but Detroit Edison paid in Federal, state and local taxes, $54,512,895 and Consumers Power paid $42,809,704, or a grand total of over $97,000,000. In spite of this the Federal agitation constantly has been to set up more groups throughout the nation. This same threat now faces medicine. The bureaucrats and the socialistic planners have turned to the medical profession as much easier victims.

The experiences of the President's Conference on the Aging in January indicate to what extent these people will go to accomplish a purpose. They reported large numbers of groups who voted to put the care of the aged under Social Security. Those figures were not true and have been exposed numerous times. The group voting on that particular item had only one doctor in it, but did have bureaucrats and dedicated labor representatives who absolutely buried a minority report and issued a report favoring the social security angle.

This Matter of Living

Here in Michigan, the medical profession has one measure opposing socialization of medicine. In the 1930's it developed its Blue Cross and Blue Shield program. This was not a perfect organization but it was a working one and it could and did care for the lower income and middle income groups with very little complaint. The higher income groups (over limit groups) in some instances had disagreements. That need not have been.

For years and throughout the course of pre-paid medical services, the Michigan State Medical Society has advocated that doctors and patients talk over their fees before service is rendered, or at the time it is rendered and have an understanding as to extra charges. Had that been done there would have been very little dissatisfaction.

Now we are passing through another era. For some reason, for the past five years, the insurance department has kept Medical Service working in the red with inadequate rates to carry the load. The Blue Shield contracts provide for very special services needed in many of the newer procedures which were unknown half a dozen years ago. Naturally costs have gone up, yet every time there is a request for increased adjustment, we have had a publicity blast.

The Medical Society and Medical Service has had unfair criticism from newspapers, bureaucrats, from critics all over with very unfavorable publicity. Most admit proper work is being done satisfactorily, but it is a chance to criticize—not the individual doctors—but the group. A feeling and a tension has been building up which adds to the recently developing general drive for socialization. The leaders of the profession, national and state, believe we have never faced a more serious or more threatening time than right now.

Another Bill (HR 4222), was introduced as a substitute for the Forand and others, on February 13, 1961, by Congressman King of California. This is very definitely socialized medicine. It provides for compulsory care and amends the Social Security Act to provide health benefits for the aged.

This new "Health Insurance Benefit Act of 1961" (HR 4222), expressing the program of the Administration, is shrewdly written, and vicious. It specifically denies being socialized medicine. It has a section prohibiting any department or official from dominating or in any way influencing or suggesting medical actions. It gives hospital and other benefits, but gives the pa-

tient full choice in selecting his own hospital or *doctor* and specifies that no medical or surgical benefits are given—attempting to avoid the charge of socialized medicine because it is not medical or surgical and makes no provision to pay such. It specifically excludes medical or surgical services provided by a physician, resident or intern except in the field of pathology, radiology, physiatry or anesthesiology. . . .

This is very cleverly drafted to disavow socialized medicine and interference. But hospital services must be under a physician and his orders. Also the pathologists, radiologists, physiatrists and anesthesiologists are physicians.

This Bill was written to misinform the public in the belief it does not involve physicians, and also the older people who have been led to believe medical care for their older years was promised.

The American Medical Association called a special conference with representatives from every state who met in Chicago, March 18-19, to consider this Bill. The general opinion was that if this Bill should become law—as it very seriously threatens to do—that would be the end of the private practice of medicine in the United States. Doctors are now working under very favorable conditions with the insurance principle and pre-payment paying a large percentage of their bills. Blue Cross and Blue Shield alone cover nearly 50% and there are thousands of private insurance companies carrying this service too. It is estimated that nearly 80% of our total population and of the retirement age group now have some form of prepaid health insurance.

This proposed King-Anderson Bill (HR 4222) would immediately take over everybody over 65, who's under the Social Security system, the blind, the dependent, the handicapped. Passing this Bill would breach the barrier now in force against compulsory health insurance by putting 15 to 20 million people in it. What would prevent an ambitious person wanting votes to change that limit to 60 years, or 50 years, or 35 and then ultimately to wipe it out completely.

That is the foot in the door about which medical leaders nationally and locally are very seriously concerned.

Special House of Delegates Session

The Council of the Michigan State Medical Society at an emergency meeting held March 26 in Lansing, considered the impending problems and voted unanimously to request the Speaker to call a special session of the House of Delegates of the Michigan State Medical Society.

These special sessions have been held at rare intervals, but never for a more far reaching and impelling reason than the problems facing Michigan Medicine today. The special session of April 16, 1961, will be history by the time this editorial reaches our readers. The advice and counsel at that special session will then be in the process of implementation. The socialized medicine threat demands constant observation, but now as a corollary to opposing and fighting these particular measures, we invite attention to the Blue Cross and Blue Shield programs which staved off this threat 20 years ago. The united determined support from our membership will again help us. Within the last few months we have placed into effect and made available throughout the United States, another enactment which could demonstrate to the public that the social security method of compulsory care is not necessary.

McNerney Report

In this issue of THE JOURNAL, we are publishing a McNerney report. This is almost a duplication of a speech given by Professor McNerney to The Council and the Conference of Public Relations and County Officers on January 29, in Lansing. Until now, the professor has refused to give anything in writing which could be published. This material was received on March 20 and immediately rushed for emergency setting and publication.

The Publication Committee and the Editor believe this material is so vitally important, especially in this time of stress, uncertainty and impending difficulties, that every member should have an opportunity to read this whole report. It contains basic information from a five-year study. It points out what could happen to the private practice of medicine, what the doctors must do to avoid that condition and how they can preserve the right to practice medicine as individual citizens.

We urge our members to read this whole article, not once—but twice, and consider seriously his own individual reaction. We appreciate that many of our doctors do not believe the stories of the threat of socialism, but our pioneers, our administrators, nationally, state wide and locally, appreciate that a very desperate change is in the making, unless we are able to re-establish the happy confidence of our patients in the true significance and implication and accomplishments American medicine has made in the last generation, and especially in the last five years.

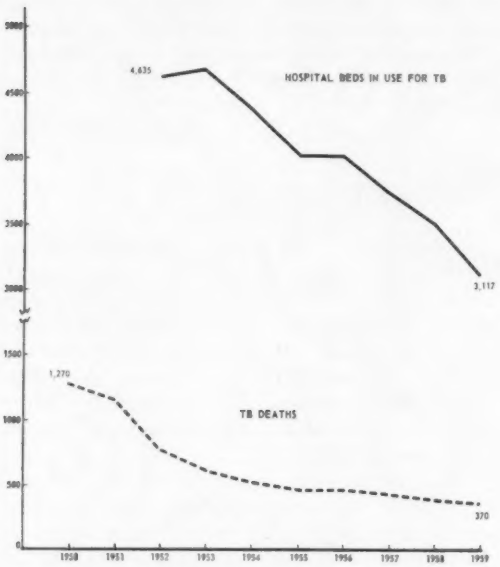
Please read the article. Not with resentment, but as the considered recommendation of the group of devoted investigators who have studied the medical profession of Michigan for nearly five years.

We hope the final report will be available soon, but until then, this is what we have.

Guest Editorials

An Old Pattern for New Progress

A few hundred meetings ago, one of our distinguished colleagues asserted that the way things were going, we wouldn't conquer tuberculosis in a thousand years. At that time, patients were waiting for sanatorium beds, and the see-saw record of tuberculosis cases showed apparently little reason for optimism.



Emphasis on early diagnosis, prompt and modern treatment, and rehabilitation have helped bring about this dramatic progress against tuberculosis. Along with the cut in deaths and the declining need for hospital beds, the total number of new tuberculosis cases reported yearly (both active and inactive) has dropped from 5,538 in 1950 to 4,743 in 1959.

Fortunately, the thousand-year prophecy was not unalterable. Some perserverence, with more than a dash of statesmanship, has paid off. Not that we've finished with tuberculosis, but we have made immense progress and can take much satisfaction in what has been done. More important, we can take from this experience some good tactics for use in other places. Particularly, we can apply what we have learned in tuberculosis to deal more effectively with other chronic diseases and mental illness. We can use the old pattern for new progress.

A LOOK AT TUBERCULOSIS TODAY shows a sharp reduction in deaths, a significant reduction in cases, and a declining need for tuberculosis hospital beds. Some local sanatoriums have been converted to use as general hospitals or for chronic disease patients. Mental patients have been admitted to state sanatoriums. And we are in the process of trying to work out the transfer of the Michigan State Sanatorium at Howell to the Department of Mental Health. This continuing advance was brought about by a working partnership of private medicine, official public health and voluntary agencies in a three-pronged attack. We said:

1. Let's work together for the early diagnosis of tuberculosis.
2. Let's insist on prompt and modern treatment.
3. Let's help the patient get back on his feet with rehabilitation.

As many readers of THE JOURNAL MSMS know, it is seldom easy going, making those three things work, but the results speak for themselves.

IN CONTRAST WITH TUBERCULOSIS, our situation with chronic diseases and mental illness is characterized by long periods of disability and hospitalization, the continuing upward spiral of hospital care costs, and the demand for more and more facilities. There is currently a backlog of 79 Michigan hospital construction projects which would cost $125 million and are eligible for Federal Hill-Burton matching funds, if we had the money. There are increasing demands for nursing home beds and the well-advertised waiting list at mental institutions. Private and public health practitioners alike have an opporunity, if not an obligation, to try to establish in these fields the same concepts employed in tuberculosis.

In govermnent programs touching these fields, let us, together, strive to establish a high priority for early diagnosis. A case in point: the possibilities for public screening programs for diseases such as diabetes and glaucoma. Let us, together, strive to develop care which is not only most effective but also most economical. Here we might well ask how we can act most expeditiously to supplement Michigan's first class hospital care with first class home nursing care, not only in areas where these services already have been started, but also in the sixty counties of the state which virtually have no such service available. Let us, together, give the techniques of rehabilitation something more than lip service. We can no longer afford the luxury of warehouse storage for the patient who might be put back on his feet by proper treatment in a quality nursing home or in a rehabilitation unit.

BESIDES ADVANTAGES IN HEALTH AND ECONOMY, this approach would reinforce private practice. As familiar examples, there is the screening program which can reach the woman with unsuspected cervical cancer in time for early diagnosis and suc-

cessful surgery, the visiting nurse who can assist the amputee in learning to hobble around on his new prosthesis, and the physical therapist who can help save the coronary patient from vegetating in a nursing home bed. Building the concepts of early diagnosis, prompt and modern care, and rehabilitation into government health services thus augurs well both for the practice of medicine and for the health and pocketbooks of the people. The gain can be made only with the energetic leadership of the doctors of Michigan.

ALBERT E. HEUSTIS, M.D., M.P.H.
State Health Commissioner

Our Largest Disease Syndrome

Human nature plus alcohol and sales promotion causes our largest disease syndrome, including physical and mental disease, premature death, delinquency, crime, broken homes, mental anguish, poverty, and reduced national vitality.

The American Medical Association states, "Chronic Alcoholism in the United States has reached the alarming degree where it directly affects about 20 million people, who are the families of alcoholic patients, estimated at almost 5 million. Indirectly, every man, woman, and child in the United States is affected sociologically, psychologically, and economically by this problem," . . . and . . . "This offers to the medical profession a challenge it cannot ignore."

The acute problem drinkers increase those directly affected to 40 million, or one alcoholic in every 4½ homes. It costs State government $5.00 for every $1.00 received in liquor revenue. $1.00 comes out of every $25.00 of wages, or 16 billion, or one-third the national defense.

One state reports 20 per cent in its mental institutions are alcoholic. No state can provide enough mental hospitals at $20,000 per bed for construction alone. At Michigan Southern Prison, the largest in the world, 49 per cent are alcoholic, and 10 per cent drug addicts. Who all constitute the accomplices to this 49 per cent?

One and one-half million crimes in the United States in 1958 were up 9.3 per cent over 1957. Of the 10 per cent crime increase among youth under eighteen, 81 per cent were for driving while intoxicated. Population increase was 1.7 per cent during the same period. Death on highways was 50 per cent alcohol connected. In 75 per cent blood tests were demanded. For each death, there were 106 injured.

The University of Michigan reports: "In terms of conduct, drinking is the number one problem of higher education in regard to the individual and his group."

March 29, 1961: Troops called out at Bowling Green State University. Student demands include relaxation of bans on drinking on or off campus.

Hillsdale College: Friend kills friend after day with beer.

Being a habit-forming narcotic, alcohol is automatically propagated in addition to advertising and sales pressure of all kinds by all who profit from it, so now 75 per cent of Americans drink beginning in high school, producing over 1000 new chronic or acute problem drinkers daily in comparison with 20 cases of polio under disease prevention.

The AMA carries no liquor advertising in its extensive publications for obvious reasons.

Liberty to drink under the law is one thing, but liberty for money, to persuade youngsters during the years when conformity is natural and one out of fifteen becomes a chronic alcoholic, is something else.

During World War II, there was great concern over the physical unfitness of recruits. Our government has just appointed an athletic director and football coach as special consultant for a National Youth Fitness Program, while it allows the alcohol interests to sponsor TV and radio sports programs.

Alcohol subverts the mind and damages brain and body tissue. We would remonstrate with action if a foreign nation sabotaged our man power. No American wants this.

If prohibition established today could really prohibit, one million people could shortly go into convulsion, coma, and death. Alcoholics want to get well. They suffer terribly. Education, understanding, and treatment, together with elimination of all types of advertising is needed. America wants disease prevention.

The AMA has stated the problem. We know the method and our duty to join with the courts, penal institutions, industry, labor, education, government, and others to reduce this disease.

Silence by the major political parties on this subject negates their efforts at health, education, welfare, and disease prevention.

Slavery of 100 years ago built mansions for some and hovels for many. Millions are now under bondage to alcoholism.

Massive information directly to the people by the health professions regarding this growing national catastrophe would raise the hopes of the millions of Americans directly affected, and the appreciation of the whole nation.

RALPH H. PINO, M.D.

Report of Speaker of the House of Delegates to The Council

Special Session of the MSMS House of Delegates, Sunday, April 16, 1961, at Kellogg Center, Michigan State University, East Lansing

On subject date the House of Delegates of MSMS convened in special session for the purpose of discussing implications of H.R. 4222 in the Federal Congress which proposes health services to the aged through the Social Security system, and to develop and implement a necessary informational campaign to the public through MSMS members. Seven work groups discussed these matters. Following are the official reports of the work groups as adopted by the House of Delegates in plenary session:

Reports of Work Groups

I. "Financing the Program"

"This workshop committee was furnished information regarding the monies available for this program in a communication from Dr. O. B. McGillicuddy, Chairman of the Finance Committee of The Council. A total amount of $6,450.00 is already in three Public Relations accounts, with an additional $35,000.00 in a Public Relations reserve presently invested in Government Bonds. The General Reserve fund of the Society amounts to $22,000.00 and must be maintained in reserve for extreme emergencies only.

"It should be pointed out that this is a long-range program of many years' duration and that the timing of our maximum effort cannot be predicted at the present time. The proposed 12-month budget submitted by Mr. Brenneman of which you have received a copy requests an outlay of $24,450.00. This budget was reviewed with Mr. Brenneman and your Committee does not recommend any change in the listed items. It was the consensus of the Committee that the financing of this continued program would without doubt be reconsidered by this House of Delegates at their regular Annual Session in September, 1961.

"This Workshop recommends (1) that the proposed plan of action as submitted by Dr. Engelke this morning be approved; (2) that $10,000.00 be made available for the remainder of this fiscal year ending November 30, 1961; and (3) that The Council be authorized to allot additional monies from funds presently available in case of an emergency need in carrying out this program. Mr. Speaker, J. M. Wellman, M.D., Chairman, *moves* the adoption of this report."

The motion was seconded by Charles W. Oakes, M.D., and unanimously *carried.*

II. "Communicating with Doctors"

"Mr. Speaker and Delegates, as a result of our Workshop discussion and study, the following recommendations are made regarding communicating with doctors:

"1. Mailings to all MSMS members: the workshop participants recommend that all mailings should be as brief as possible and printed for greater legibility. It recommends that an initial letter be sent which would give basic current information. Subsequent mailings would provide periodic up-dating of information and status of legislation. Strongly recommended was the establishment of a set of addressograph plates for each physician's home so that information could be sent to doctor and his wife. It was felt that this would accomplish two purposes—contact the important Auxiliary member and permit the physician to review material outside busy office hours. It was agreed that these plates should not be used by any group other than MSMS. It was felt that over a 12-month period, three mailings to all MSMS members would be necessary.

"2. Mailings to Campaign for Freedom Chairman and committees: the workshop agreed that this established list of interested doctors might serve as a nucleus of physicians who would desire to be informed to a greater degree than all MSMS members. These physicians were appointed by all county medical societies in 1960. If MSMS found it necessary to get information out quickly, this list of physicians could be contacted by telegram and then relay message on request by person to person contact. It was agreed that over a 12-month period, six mailings might be necessary.

"3. Preparation of printed bulletins for reading by the Secretary and/or distribution to physicians attending county medical society meetings: the workshop participants recommend that these bulletins be prepared periodically. It was believed that this distribution method would be effective and economical.

"4. Press releases to county medical society publi-

cations: since a majority of physicians are members of county medical societies which publish a bulletin, this workshop urges that regular press releases be sent to editors to augment information appearing in publications of MSMS and AMA.

"5. Contact through hospital staffs: it was recommended that information be disseminated through chiefs of hospital staffs, especially in more highly populated counties. Specifically, that hospital staff meetings be utilized as a forum for discussion and brief informational reports.

"6. Mailings to legislative report list: the workshop recommends that this group of approximately 600 continue to receive special legislative information throughout the year.

"7. Contact with delegates: it is recommended that the MSMS consider this a key contact group to receive detailed information and keep them constantly informed of current status of national legislation. This group should be an important action group. Delegates should be included in all mailings to Campaign for Freedom chairmen and committees.

"8. Regional legislative conferences: the workshop believes that person to person contact is essential to a successful information campaign and recommends that legislative conferences be held.

"9. Speakers Bureau: one-day training sessions: the workshop believes it highly desirable to hold a one-day training seminar to bring together speech experts and physicians who desire to improve their speaking abilities. Several speeches on different aspects of the problem should be distributed. County medical societies should be urged to enlarge their speakers bureau. Mr. Speaker, R. Wallace Teed, M.D., Chairman, *moves* the adoption of this report." The motion was seconded by Charles W. Sellers, M.D., and unanimously *carried*.

III. "County Medical Society Programs"

"The County Society as an organization stands between the State Society Officers and the grass roots or individual physicians. The County Society is sensitive to local feelings, and is therefore in an ideal position to interpret a general campaign to the local citizens. Secondly, the county society must be the body that checks up on the individual physician, on the good doctor who ignores political facts, and the bad doctor who gives medicine a terrible handicap by overcharging.

"Your committee believes that the county society must organize local action; interpret to and educate each physician, and constantly inspire and drive him to active participation in this campaign. There is no one else to insure that each member does his part.

"Your committee favors the expectation that each physician deliberately plan and intend to discuss the facts with at least one patient daily, and to devote at least one hour weekly to promoting our campaign by correspondence or other means. Toward this, our able Vice Speaker suggests the slogan: 'One Hour a Week For Freedom.'

"A big sore in medical public relations is the variation in financial charges among different physicians and communities. Our attack against socialized medicine would be aided if we could develop an improved public image by developing a satisfactory solution of this problem. One method would be for members to have an advance financial understanding with each patient. Your committee finds some lack of full understanding of the workings of the Kerr-Mills Bill, and believes there is a need for further education of physicians and county aid officials on that subject.

"Your committee recommends that each county society promote and fully support its Womans' Auxiliary, for they can be of inestimable value and true auxiliaries, in promoting our campaign among the citizens, and in educating the public. The same support should be given similarly to Medical Assistants Societies.

"Mr. Speaker and delegates, as a result of our workshop discussion and study, the following recommendations are made regarding county medical society programs:

"1. Regional conference: in order to inform and inspire county society leaders and officers, we recommend that The Council organize four regional conferences to be held as soon as possible, on a Sunday. One would cover the Councilor Districts of the Detroit metropolitan area, one the lower portion of the Lower Peninsula, one the rest of the Lower Peninsula, and the fourth the Upper Peninsula. Those invited should include delegates and alternates, councilors, county society officers and board, PR officers and other appropriate officers. MAP officials could well be invited as guests.

"2. Report on special House of Delegates session to county societies: your committee recommends that each delegate report at the earliest opportunity the facts and spirit and importance of this meeting today. Each county group of delegates should determine the most effective method of informing their officers and members. To aid this, the state society office should send to each delegate and to county society officers a report of this meeting. We recommend that Dr. Drolett be asked to put the outstanding talk that he gave to us this morning on tape so that it can be used at county society meetings and possibly other meetings. Many small societies lack inspiring speakers; this would help fill the vacuum. We also commend this talk for reproduction for mailing to each M.D. in the state.

"3. *Exchange of Ideas Newsletter* to C.M.S. officers: an *Exchange of Ideas Newsletter* for mutual interchange of ideas between county society officers would be of value, provided that function is not covered by existing publications. It would require active co-operation by county officers to be of value.

"4. County society bulletins: we recommend that county society bulletins devote a good share, perhaps a third, in each issue to material aiding this campaign.

"5. Neighborhood coffee meetings: your committee supports the proposal for coffee meetings of neighborhood wives and friends. Literature and other aids should be made available for these meetings.

"6. Local newspaper ads: your committee supports the placing in local newspapers of the advertisement which the AMA will place in metropolitan papers.

Mr. Speaker, Don Marshall, M.D., Chairman, *moves* the adoption of this report."

The motion was seconded by Jacob F. Wenzel, M.D., and unanimously *carried*.

IV. "Media"

"It was felt that the function of this workshop on Media was to develop methods of reaching the people of the State of Michigan and to inform them of the contents and implications of the King-Anderson Bill, and the positive and preferred aspects of Medicine's program. The media channels considered by this committee consisted of the following: (1) press; (2) radio; (3) television; and (4) doctor-patient communication.

"It was the consensus of the committee that the most important and effective channels to the general public were the press, and doctor-patient communications.

"In pursuance of these aims, the following resolutions were favorably considered and are recommended for submission to the House of Delegates for approval:

"1. RESOLVED, that press relations should primarily be the responsibility of a public relations or press committee of each county medical society. Where publications are on a state-wide basis, however, the responsibility should be shared by the Public Relations Committee of MSMS. Every county medical society which does not at present have a PR or press committee should be urged to create one forthwith. The following techniques, with regard to press relationship were suggested for use by the county medical societies: (A) development of personal contact between appropriate members of the society and local editors, in order to present medicine's position and to enlist favorable editorial support; (B) sponsorship by each county medical society of advertisements on local newspapers such as those proposed by the Communications Division of AMA; (C) enlisting of support of local representatives of the National Retail Association and Chamber of Commerce in strengthening liaison with the press; (D) encouragement of letters from non-medical personnel to the editors, to support medicine's position; (E) publication of articles in special interest newspapers and magazines such as local shopping news, organization publications, etc.

"2. RESOLVED, that the media of radio and television be under the direction of the MSMS Public Relations Committee and that the utilization of radio and TV time and audio-visual media should be determined by this committee.

"3. RESOLVED, that doctor-patient communications be implemented with a poster bearing appropriate information concerning the King-Anderson Bill, together with an invitation to the patient to discuss this matter with his physician, and that this poster be distributed to every member of the MSMS for display in his office.

"4. RESOLVED, that a revised pamphlet be prepared by MSMS which emphasizes the positive aspect of the Kerr-Mills Act, and which exposes the dangers inherent in the socialized medicine King-Anderson Bill (HR 4222).

"And be it further resolved, that information from AMA publications, along with information applicable particularly to Michigan should be incorporated into a single pamphlet; and be it further resolved, that the above mentioned poster be equipped with a box to contain the proposed pamphlet.

"The media committee took under advisement a resolution submitted by Dr. Charles Sellers which implied financing of the cost of newspaper publicity. No action was taken on this resolution because this matter was thought to be more appropriate for consideration by the special committee entitled 'Financing the Program.' Mr. Speaker, Jack Rom, M.D., Chairman, *moves* the adoption of this report."

The motion was seconded by J. Leonidas Leach, M.D. and unanimously *carried*.

V. "Legislative Contacts"

"Mr. Speaker and delegates, as a result of our workshop discussion and study, the following recommendations are made regarding legislative contacts:

"1. Committee of 10 per cent program as in Campaign for Freedom to obtain letters to Congressmen: we recommend the re-establishment of the technique of 'Committees of 10 per cent' and further recommend the extension of this technique to hospitals, medical, nursing and pharmacy schools, and other ancillary groups.

"2. Washington, D. C. trip to Congressmen's offices: in addition to endorsing the MSMS trip to

Washington, D. C., we recommend that county medical societies send groups to Washington for personal contact with Congressmen, that individual physicians (and their friends) be urged to visit their Congressmen while in Washington, and that such contacts explain medicine's stand against socialism (and HR 4222 in particular) and stress medicine's positive program for the care of the aged and the American people generally, and that all this be done in a diplomatic atmosphere as opposed to one of controversy.

"3. Petitioning of Congressmen, from CMS and others, by formal resolutions: We recommend encouragement of county medical society resolutions, and further recommend that county medical societies urge allied professional groups, chambers of commerce, farm bureaus, etc., to also petition Congressmen in support of our position.

"4. CMS meetings with legislators at home: we recommend that informal meetings (as opposed to formal county medical society meetings) be conducted for the purpose of meeting with both state and national legislators so that they and physicians can better understand each other's problems and views.

"5. Activation of list of personal physicians of Congressmen: we disapprove of this technique.

"6. We recommend that in all legislative contacts, by whatever technique, physicians observe certain protocols, including in particular:

(A) Be positive, and stress what you are for (Kerr-Mills Bill);
(B) Be friendly, not critical or antagonistic;
(C) Be concerned, with the effect of socialism on your patients as citizens of a free nation;
(D) Be proud, that medicine has made more progress in our American atmosphere of freedom than anywhere else in the world;
(E) Be certain, that socialism once started can never be stopped and eventually results in ruinous taxation.

Mr. Speaker, John G. Slevin, M.D., Chairman, *moves* adoption of this report." The motion was seconded by Vernon V. Bass, M.D., and unanimously *carried.*

VI. "Working with Others"

"Mr. Speaker and delegates, as a result of our workshop discussion and study, the following recommendations are made regarding working with others: our workshop had a most stimulating and I think fruitful discussion on this subject. Our report may not include many of the basic ideas that need further exploration and discussion. In general, we said 'yes' to the suggestions made on the Presidents Program, but decided that mailings to individual groups or contacts in meetings of representatives ought to be made by the medical profession with a much firmer and a more concise concept of the subject. Therefore, we talked about (1) defining what we are for, and (2) defining what we are against. We think it important that we prepare and state simply in as few words as possible an outline of these objectives so that we will have a uniform 'battle cry.' This 'battle cry' can then be tailored for presentation to an individual, to a small group, or to a mass audience, as in the suggested mailings. Both a capsule presentation and a formal address ought to be formulated. We have agreed that multiple key words and phrases ought to be included, such as 'the subject which we are against has Communistic approval,' that 'Social Security represents a tax,' and that 'a basic problem with our communication with others is a lack of understanding of the doctor's philosophy.' We feel that the most receptive audiences for our message would include: service clubs, chambers of commerce, church groups, PTAs, college level groups, MEAs, medical students, boy scout and Y groups, your own kids, and your wife.

"1. Establishment of editorial contact list: we reviewed and accept the AMA pamphlet of editorial material and we urge their 'personal' distribution to editors of your community news media. These might include not only your daily or weekly papers but fraternal, church and trade publications.

"2. Statewide meeting with ancillary and interested groups, and arranging for speakers via a statewide speakers bureau: believing that increased federal control is our greatest danger to the preservation of our civil rights, we therefore propose meetings of all ancillary and interested groups with similar problems for discussion, formulation, and concerted plans for integrated action. Establishment of a state speakers bureau and a complementary speakers bureau at either a county or a councilor district level, will be the key to the success of these meetings. The delegate should remember, however, that each physician is a speaker in his own right and to his own patients of the aims and desires of this program. For example, in counteracting the approval of the National Council of Churches of the King-Anderson Bill, it would be well for each doctor to personally visit his own minister or priest or rabbi, prepared to discuss or answer questions concerning this program. This discussion group feels that it is a lack of information, or a misinterpretation of the facts, that has led the national organization to approve such a measure. By attacking it at a local personal level, clarification of the issue could be accomplished and the simultaneous contact of representatives at a state level, with the Michigan Council of Churches, would be a progressive step towards them publicly reversing their decision. This same example could be utilized with farm groups, chambers of commerce, or professional groups that are experiencing

the same loss of individual decision and rights exerted by the growing federal power.

"3. Woman's auxiliary, medical assistants, Michigan Health Council list, Michigan Association of the Professions membership and Health Insurance Council: we heartily approve the use of the facilities of the above in the mailing of material to these organizations. Attention should be drawn to the cards on your desks publicizing the Michigan Health Council State Conference on May 23-24-25. This meeting is appropriately timed and will include representatives of all these interested organizations. This is a most opportune occasion for us to clearly delineate this program's objectives. We are fortunate in that Dr. Annis, as the banquet speaker, will amplify our theme. Any of the delegates who have 'hard to convince' individuals in responsible positions of groups that are adverse to our program could be brought as guests to this meeting, which is open to the general public. I think that the main idea that evolved from our discussion group is that the Society state clearly its program's objectives. Effort made to arrive at these clearly stated objectives will be of the greatest use to its speakers, its mailing programs, and its members at large. We want to thank all of the delegates and guests who participated in the discussion, and in particular Drs. Paul Ivkovich, Dave Bowman and our Councilor Jim Dehlin. Mr. Speaker, James D. Fryfogle, M.D., Chairman, *moves* adoption of this report."

The motion was seconded by A. Carl Stander, M.D., and unanimously *carried*.

VII. "Establishment of Position and Policy of Michigan Medicine"

"RESOLVED, that the House of Delegates of the Michigan State Medical Society meeting in special session mobilize its full resources and call upon *every physician* and constituent and component medical societies to:

"1. Continue to *provide the world's highest quality of medical care* to all our citizens;

"2. Impress upon the citizens of Michigan that the responsibility for financing one's own medical care rests first with the individual, then his family, community, county, state, and only if these should prove inadequate and *as a last resort* the Federal government;

"3. Assist all *who need help* in meeting the cost of medical care;

"4. *Vigorously endorse and promote voluntary prepayment medical care plans* as the most satisfactory method of financing the cost of medical care and to support the program initiated by the Michigan State Medical Society in the form of Blue Shield and Blue Cross Plans;

"5. Acquaint the public regarding the dangers of using federal tax mechanisms as a means of financing the cost of medical care for all *regardless of need*;

"6. Be it further resolved, that the Michigan State Medical Society shall actively support all groups having similar aims for the preservation of freedom of citizens *as opposed to centralized governmental controls*;

"7. We strongly believe in and vigorously support *individual initiative, individual responsibility and personal freedom* for all Americans;

"8. *We call upon each and every individual member* to implement the above and to encourage active participation in formulating our Country's future;

"9. And be it further resolved, that the Michigan State Medical Society will *actively and aggressively oppose HR 4222 (the King-Anderson Bill)* and all similar legislation which would in fact socialize the practice of medicine in the United States. Mr. Speaker, Robert L. Novy, M.D., Chairman, *moves* adoption of this report."

The motion was seconded by Claude L. Weston, M.D.

The Speaker called for discussion on the motion.

It was *moved* by Jacob F. Wenzel, M.D., and seconded by Alexander Blain III, M.D., that (2) above be amended to strike "As a last resort the Federal Government" and substitute therefore "and never the Federal Government." After discussion the House of Delegates voted and the motion was *defeated*. It was *moved* by Sidney Adler, M.D., and seconded by James D. Fryfogle, M.D., that (4) above be amended to strike "in the form of Blue Shield and Blue Cross plans." After discussion the House of Delegates voted and the motion *carried*. Paragraph 4 above was thereby amended to read: "Vigorously endorse and promote voluntary prepayment medical care plans as the most satisfactory method of financing the cost of medical care and to support the program initiated by the Michigan State Medical Society."

The Speaker then put the motion to adopt the report of the work shop on "Establishment of Position and Policy of Michigan Medicine," as amended.

The motion *carried* and the report, as amended, was adopted.

The Committee to establish position and policy submitted the following report:

"We highly commend and ask the support of the program proposed by Dr. Otto K. Engelke and presented to this House of Delegates and ask that it be actively implemented by the Michigan State Medical Society, its constituent county medical societies *as well as each individual physician in the State of*

(Continued on Page 652)

Statement of Principles For Lawyers and Physicians

(The following statement was developed by a special conference committee of the Michigan State Medical Society and the State Bar of Michigan in 1957, and was approved by both organizations. There have been many recent requests that the statement be reprinted.)

Preamble

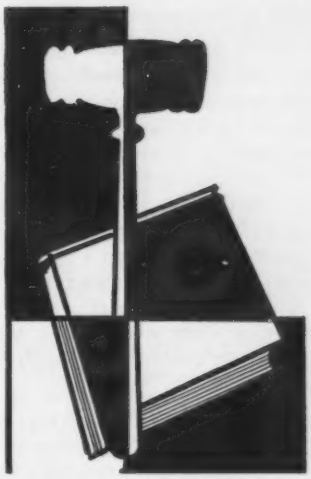
In recognition of the public service obligations common to the medical and legal professions, and in the belief that such action will promote a closer cooperation and assist in maintaining a harmonious and compatible relationship between the two professions, thus serving the public interest, the Michigan State Medical Society and the State Bar of Michigan do hereby adopt the following Statement of Principles governing physicians and lawyers.

Medical Reports Requested by Attorneys

1. Where a report is requested by the patient's attorney, upon authorization from the patient, the physician should furnish to the attorney such report with reasonable promptness.
2. The contents of such report should be such as to permit the attorney to protect the interests of the patient fully and properly and compatibly with the attorney-client relationship.
3. When requesting such report, the attorney should clearly specify the information desired, and make known to the physician whether or not it is to embody opinions regarding diagnosis, prognosis and disability evaluation.
4. The attorney should recognize that it is not always possible for the physician to prepare a medical report on short notice. Where the physician may indicate that he deems it necessary or advisable before submitting such report to have the opportunity of seeing and examining the patient, the attorney should co-operate with the physician by arranging for his client to be seen by the physician.
5. When a medical report is requested by an attorney, he should not take the time of the physician for a conference unless:
   (a) It appears to the attorney that a conference is necessary for a proper report or
   (b) The physician requests such a conference before furnishing his report.
6. After the physician has furnished a report, if either the physician or the attorney feels it necessary or desirable to hold a conference with reference to the contents of the report, the attorney should be cognizant of the demands of time made upon the physician, and should co-operate to arrange such conference at a time and place indicated by the physician to be most convenient and suitable.

Co-operation Between Physician and Attorney In Cases Expected to be Tried and Where Attorney Proposes to Present Physician as a Witness

1. It is the duty of the attorney to furnish to the physician reasonable advance notice that the case is approaching trial, and that the physician is expected to be called as a witness in the trial of the case.



2. It is the duty of the attorney to make inquiry and ascertain from the physician as to any hospital records in appropriate cases, or other records not under the direct control or possession of the physician, including x-rays or reports the physician desires to have available at the time of his being a witness in the trial of the case, and to make the necessary arrangements so that such reports are thus available for the use of the physician at such time.

3. It is the duty of the attorney to request and remind the physician to bring with him at the time he appears as a witness his own office records with reference to his patient.

4. It is the duty of the attorney, after the physician requests the opportunity of seeing and examining the patient before trial, to arrange for the patient to be seen by the physician.

5. It is the duty of the physician at this time to review his own office records and any other records pertaining to his patient so as to cooperate with the attorney in the preparation of the trial of the case.

6. While the physician heretofore may have furnished a medical report to the attorney, the physician should recognize that such prior report likely was furnished for the principal purpose of permitting the attorney properly to plead his client's medical claims in the case. The physician should further recognize that at this time, for the attorney to protect fully the interest of his client, it may be necessary or advisable for the attorney to request a supplemental and amplified report in the preparation for the trial of the case, and it is the duty of the physician to cooperate with the attorney where authorized by the patient to furnish such supplemental and amplified medical report.

7. In some cases, it should be recognized by both the attorney and the physician that it is necessary or most desirable that a conference or conferences be had between the attorney and the physician in advance of the physician appearing as a witness in the trial of the case, whereby the physician is afforded an opportunity of discussing with the attorney the medical aspects of the case from the physician's viewpoint, particularly any technical medical matters pertaining thereto. An opportunity is thus afforded to the attorney of discussing with the physician the legal rules and the position occupied by the physician as a witness in the trial of the case, resulting in mutual cooperation for the best interest of the patient of the physician and the client of the attorney in the presentment of the case in court. Where, however, the physician and attorney mutually agree that such a conference is unnecessary, it should be avoided in the interest of saving the time of both the physician and the attorney. Where such conference or conferences are deemed necessary or advisable, the attorney should recognize a duty to arrange for the time and place for such conference or conferences as most convenient and suitable to the physician.

8. It is the duty of the attorney, in accordance with the ethics of his profession, that under no circumstances should he seek or attempt, in any manner, to persuade the physician to distort or color his testimony.

9. The physician should recognize the moral, as well as the legal, obligation of appearing in court as a witness on behalf of his patient, and should understand that medical testimony is frequently indispensable to prove or disprove medical claims presented in a case.

The Physician as a Witness in the Trial of the Case

1. It is required that parties, attorneys and witnesses, including physicians who are called to testify, recognize that the administration of justice by the courts and the trial of cases by the judges thereof cannot depend upon the convenience of such persons.

2. The attorney owes a duty to the physician who is to be a witness in the trial of the case to notify him as far in advance as possible as to when he is to be needed to testify, and to keep him informed and advised as to any changes with respect to the time of his appearance in court as the trial develops.

3. The attorney should notify the physician promptly of any settlement or other development during the trial of the case, the result of which is to eliminate the calling of the physician as a witness in the trial, so that the physician, who likely has set aside the time in which he is expected to be in court as a witness, may have the opportunity of making other commitments for this time.

4. The attorney should have available for the physician when he appears as a witness, all hospital and any other records which the attorney and physician have theretofore agreed shall be at the place of trial for the physician's use.

5. The physician should attend court at the time appointed. The attorney should appreciate, however, that a physician has continuing and often unpredictable responsibilities to his patients. Insofar as the attorney is able, he should make arrangements to permit the physician to testify with a minimum of inconvenience and delay to him.

6. The physician while testifying should answer questions as concisely and objectively as possible, with a terminology, when permissible, which will be most understandable to a jury of laymen.

7. If the physician is asked a question to which he does not know the answer, he should so state and make no attempt to speculate or guess or theorize or give answers not responsive to the question propounded, and the physician should not volunteer testimony.

8. In the giving of testimony, the physician, under no circumstances, should permit any bias, prejudice or favoritism or personal interest to influence or affect his testimony.

9. When questioning the physician-witness, an attorney should at all times refrain from unwarrantedly browbeating or badgering the physician. A physician testifying as a witness should know that if and when he feels that an attorney is improperly or unfairly conducting an examination of him as a witness, the physician may address the court and inquire if he is required to submit to such treatment.

10. The attorney owes a duty to the physician-witness to prepare and propound all questions to the witness in such form and manner as will permit a clear understanding and a forthright answer from the physician-witness.

11. An attorney who calls a physician to testify as an expert witness should, in advance of the physician's appearance in court, advise the physician of his intention to qualify and question him as an expert witness, and where it is proposed to use a hypothetical question, should in advance of the trial converse with the physician and explain to him the use of such hypothetical question so that at the time the physician in his capacity as an expert witness is propounded such question, he will have a reasonable understanding of the use of the hypothetical question and the limitations with reference to his answer to such form of question.

Compensation for Services of Physicians

1. It is the duty of the attorney, where necessary, to explain to his client the physician's bill for services and the itemization thereof. In cases where the physician aided in preparing the case but did not have the opportunity to testify or failed to testify because of a settlement prior to his being called as a witness, it is the responsibility of the attorney to advise his client of the physician's assistance and services in the case, and thus to cooperate with the physician for the purpose of seeing that such physician receives a reasonable fee for such services.

2. A physician who, at the request of an attorney, furnishes a medical report authorized by the patient, should receive a nominal fee for this service, and it is the duty of the attorney to cooperate with the physician to see that he receives such fee. If such medical report requires extraordinary services in its preparation either as to time and contents, or the case is of such a nature that the medical aspects thereof require the physician to have a conference or conferences with the attorney, or to furnish subsequent supplemental and/or amplified medical reports, the physician is entitled to a reasonable compensation for such professional services rendered, and it is the duty of the attorney to cooperate to see that such physician receives reasonable compensation in rendering such professional services. Where, after an original medical report, the physician is requested to perform further services in assisting in the preparation of the case for trial by furnishing supplemental or amplified reports and conferring with the attorney or rendering other services, it is recommended that when feasible, an agreed fee for such services be determined in advance after consultation with the attorney.

3. Where it appears that the patient is indigent or unable to make payment, the right to compensation for services in assisting the attorney in the preparation of the case for trial may be waived by the physician, or where it appears that the financial status of the patient is such that ordinary reasonable compensation to the physician for his services will work a hardship, the physician may take this into consideration in determining his fee for services in assisting the attorney in the preparation of the case for trial.

4. Where a physician testifies as a witness, under no circumstances should the physician's charge for his time as a witness, or his fee, if qualified and testifying as an expert witness, be contingent or determined by the amount of the recovery of the patient in the litigation, or the success or lack of success of the patient's case.

5. Compensation for the services of a physician in connection with assisting in the preparation of the case or for his appearance as a witness in court should be on a reasonable basis and based on the time and nature of the services performed.

6. It is the duty of the attorney to cooperate fully with the physician by assisting the physician to obtain payment for services properly rendered by the physician to his patient in the physician-patient relationship. It is the further duty of the attorney to cooperate with the physician to obtain payment from the patient for services rendered by the physician to the attorney in the preparation and/or trial of the patient's case.

Inter-Professional Courtesy and Understanding

1. For the medical and legal professions to perform the full duties owed to society by each, it is required that the members of each profession extend toward the other full courtesies and amenities and engage in a mutual understanding of the problems of each other.

2. It is required that the attorney understand the vast demands made upon the time of the members of the medical profession, and at all times to avoid unnecessarily claiming the time of any physician either in the attorney's preparation of the case for trial, or while engaged in the trial of the case.

3. It likewise is required that the physician understand that in many instances the legal rights to the patients, in litigation having medical aspects, may be properly protected only by the attorney seeking and obtaining the time and services of the physician in the preparation and trial of the case.

4. Courtesy requires, where necessary, that the attorney assist and enlighten the physician with respect to his position as a witness in the trial of the case, his role as a witness, and the rules to be observed in connection with the matter of giving testimony in court.

5. Courtesy requires of the physician that he aid the attorney so that the attorney may be enlightened on the highly specialized medical aspects of the case, and may be assisted in properly presenting in the trial of the case the medical phases involved through sufficient understanding with the physician to conduct an intelligent examination of the physician witness.

6. Courtesy requires that the attorney cooperate with the physician to minimize as far as practicable the time required for the physician to remain in court.

7. If an attorney plans to have a subpoena served upon a physician, wherever practicable, the physician should be notified in advance and service made under arrangements convenient and acceptable to the physician.

8. Courtesy requires that wherever practicable, the attorney and physician should consult in advance with reference to the fee of the physician to be charged for his time spent in attendance in court as a witness.

9. Courtesy requires that where, by requirement of statute, the amount of an expert's fee may be set only by the court, the physician be notified thereof in advance, with the further assistance of the attorney that he will petition the court, at the proper time, for an order setting a proper and reasonable fee for the physician's services as an expert witness.

Excess and Undesired Narcotics

Excess and undesired narcotic drugs may be shipped to the *District Supervisor, Bureau of Narcotics, 608 Federal Building, Detroit 26, Michigan,* by express—*charges prepaid,* for disposition. *No remuneration will be made for these surrendered drugs.*

1. Form 142 titled "Registrant's Inventory of Drugs Surrendered" will be furnished to registrants, upon request.

2. Form 142 must be prepared in quadruplicate, listing all items of narcotics being surrendered, and each form signed by the registrant or authorized agent surrendering the narcotics.

3. All the Form 142 (Original and three copies) should then be mailed to the District Supervisor, Bureau of Narcotics, 608 Federal Building, Detroit 26, Michigan, with a brief letter advising the date of shipment of the drugs, and a description of the size of the carton.

4. Ship the narcotic drugs by *Express-Charges Prepaid* to the District Supervisor, Bureau of Narcotics, 608 Federal Building, Detroit 26, Michigan.

5. Upon receipt of the drugs, a Form 142 will be receipted, and mailed to the registrant surrendering the drugs. This Form 142 should be retained in the registrant's files for a period of two years, as required by law.

Special Session of the House of Delegates

(Continued from Page 648)

Michigan. Mr. Speaker, Robert L. Novy, M.D., Chairman, *moves* adoption of this report."

The motion was seconded by J. Leonidas Leach, M.D., and unanimously *carried.*

A. Carl Stander, M.D., *moved:* "Be it resolved, that the House of Delegates of the Michigan State Medical Society express its grateful thanks to the Michigan State University and the Kellogg Center and their personnel for the fine cooperation and excellent facilities for this special session." The motion was seconded by R. Wallace Teed, M.D., and unanimously *carried.*

Louis J. Bailey, M.D., *moved:* "Be it resolved, that the House of Delegates of the Michigan State Medical Society hereby expresses its commendation to the Speaker of the House, the Vice-Speaker, Mr. Hugh W. Brenneman and his staff for the excellence of their work in connection with this special session." The motion was seconded by several and unanimously *carried.*

It was then *moved* by several, seconded by several and *carried* that the special session of the House of Delegates adjourn, the time then being 4:29 p.m.

J. J. LIGHTBODY, M.D.
Speaker of the House of Delegates
Michigan State Medical Society

AMA Auxiliary Will Fete Mrs. Mackersie

The 38th annual convention of the Woman's Auxiliary to the AMA, June 26-29, will honor the president, Mrs. William G. Mackersie, of Detroit, at the annual tea in the United Nations Building.

More than 3,000 physicians' wives will attend the Auxiliary meeting in New York City. Besides regular business sessions, presentations will be made in the fields of civil defense, safety, health careers, mental health and community service. A guest speaker will be Dr. E. Vincent Askey, AMA president.

Health Council Meeting Lists M.D. Speakers

Michigan State Medical Society members plus Auxiliary members are well represented on the program for the Michigan Health Council State Health Conference, to be held at Ballenger Field House, Flint Junior College, May 23-25.

Nineteen Society members are scheduled to speak during the three day meeting.

Mrs. William Mackersie, Detroit, president of the Auxiliary to the American Medical Association, will extend greetings to Conference participants at the Annual Banquet, May 24.

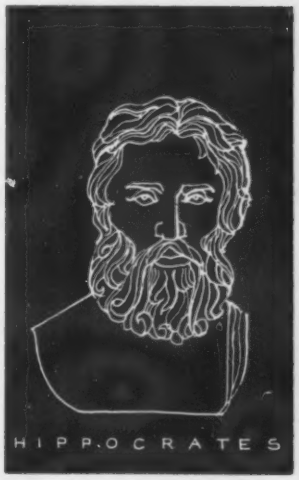
Earle Ingham Carr, M.D., Lansing, President, Michigan Foundation for Medical and Health Education, also will appear on the banquet program.

Charles J. Tupper, M.D., assistant dean, University of Michigan Medical School, is chairman of a panel on health careers, May 22. Sidney E. Chapin, M.D., Dearborn, president of the Michigan Health Council, and Harry A. Towsley, M.D., Ann Arbor, will take part in opening day ceremonies. Doctor Towsley is General Chairman of the Conference.

Mrs. Paul Ivkovich, Reed City, president of the Woman's Auxiliary to the Michigan State Medical Society, will chair a panel on the MSMS President's Program, May 24. Also appearing on the program that day are Evelyn Golden, M.D., Flint; Leslie V. Burkett, M.D., Flint; Vlado A. Getting, M.D., Ann Arbor, and Mrs. Vernon V. Bass, Saginaw, Auxiliary Health Careers Recruitment Chairman.

The second day of the Conference is also devoted to aging. Doctors appearing on the program of the Joint Council to Improve the Health Care of the Aged are A. Hazen Price, M.D., Detroit; Harry B. Zemmer, M.D., Lapeer, president emeritis, Michigan Health Council; C. Howard Ross, M.D., Ann Arbor; Otto K. Engleke, M.D., past-president of MHC; Albert H. Hirschfeld, M.D., Detroit; and Frederick C. Swartz, M.D., Lansing.

The Thursday program features Kenneth H. Johnson, M.D., Lansing, president of MSMS; Goldie Corneilson, M.D., Lansing; John Rogers, M.D., Bellair; S. D. Steiner, M.D., Detroit; J. K. Altland, M.D., Lansing, and Earle I. Irvin, M.D., Dearborn.

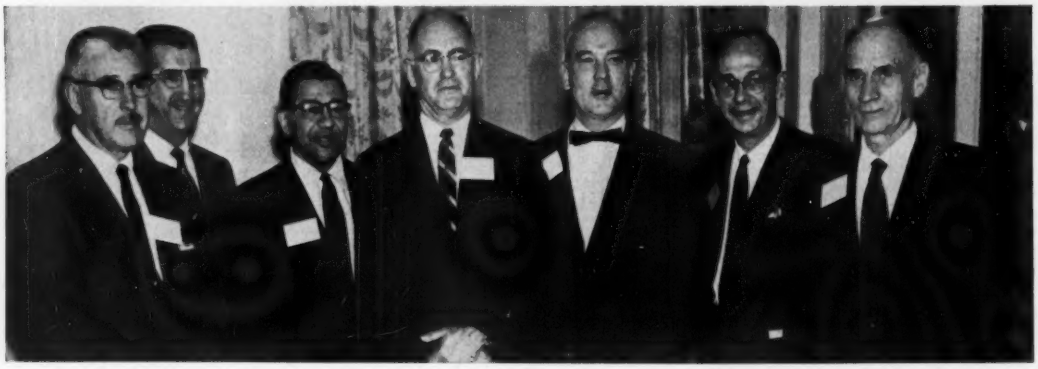


William M. LeFevre, M.D., Muskegon, first president of MAP, presides at the President's Dinner Dance.

Charles R. Sligh, Jr. *(left)*, executive vice president of the National Association of Manufacturers and keynote speaker at the Congress of the Professions, confers with Lester P. Dodd, Detroit, MSMS legal counsel, who was general chairman of the Congress.

MAP Congress

(At right) Thomas A. Francis, Jr., M.D., chairman, Department of Epidemiology, University of Michigan, discussed the "Great Accomplishments in Medicine."



MSMS members meet with state and national representatives from each member profession of MAP to explore the potential of an American Association of the Professions; its needs, services, and its relationship to existing state and national professional associations at the MAP Congress. *(Left to right)*: Drs. J. C. Day, John S. Jewell, Scipio G. Murphy, Richard C. Deming, Alexander Blain, III, Everett L. Phelps and J. R. Rupp. All are from Detroit with the exception of Dr. Phelps, who is from Hastings.

"Independence of Thought; Unity of Action," MAP Theme

The "great thoughts," "great accomplishments" and "great challenges" of the professions were the main subjects of addresses given by nationally-known speakers highlighting the 3-day program of the 2nd Annual Congress of the Professions in Detroit, recently.

Of special interest were the assemblies devoted to the great deeds of the professions.

* * *

SPEAKING FOR MEDICINE, Dr. Thomas E. Francis, Jr., M.D., professor and chairman of the Department of Epidemiology, Virus Laboratory, School of Public Health, University of Michigan, outlined the "greatest designed experiment in medical history," the polio field trial of 1954.

Philip Jay, D.D.S., professor of the School of Dentistry, U. of M., gave the inside story of fluoridation, its world-wide acceptance as a safe and practical health measure and the active opposition afforded it.

W. W. Armistead, dean of the College of Veterinary Medicine, Michigan State University, told of the great accomplishments in veterinary medicine and the part they had contributed to the advancement in human medicine.

Stephen Wilson, Ph.D., dean of Pharmacy, Wayne University, emphasized how greater specialization and diversification in the profession of pharmacy has led to its phenomenal growth.

And speaking for engineering, Dr. Harold S. Black, consultant in Systems Research of the Bell Telephone company, told of modern day miracles accomplished in the field of satellite communications. Each profession gained a greater insight and respect for the other as these accomplishments were discussed.

* * *

IN ADDRESSES STRESSING the Congress theme, "Independece of Thought; Unity of Action," other top name speakers appearing before the Congress were unanimous in their praise of MAP's leadership in mobilizing the potential strength of united professionalism as a powerful force for common good.

The keynote speaker was Charles R. Sligh, Jr., New York, executive vice-president, National Association of Manufacturers. He said that all citizens and especially the wisest and most capable must always be ready to give their best services to the community, town, city, state or nation. World tensions are great but will not prevail if our citizens are ready and willing with their counsel and effects if necessary.

The first day was devoted to six committee luncheons and hearings: Business services and techniques, Education, Legislation, Publication, Public Relations and Citizens Committee. Hearings were also held on the different areas.

In the evening was the President's Dinner Dance, with Wm. M. LeFevre, M.D., presiding. Lester P. Dodd, Detroit, was toastmaster.

During the "Great Thoughts" session three speakers gave their offerings from their professional and personal experiences: Paul A. Miller, Ph.D., provost, Michigan State University; William E. Stirton, Ph.D., vice-president, University of Michigan and director of the Dearborn Center; and C. S. Steiner, S.J., chancellor, University of Detroit. They spoke about what individuals, the professions and the people may look forward to, how to guide the future and obtain the most good for all.

The speaker at the second evening banquet was the Honorable John S. Dethmers, LL.B., Chief Justice of the Supreme Court of Michigan who spoke on "The Role of the Courts."

* * *

FIVE MSMS MEMBERS now serve on MAP's Board. They include: John W. Rice, M.D., Jackson, elected by the membership at the annual business meeting and Gilbert B. Saltonstall, M.D., Charlevoix, one of the founders of MAP who was reappointed by MSMS as its representative. Both will serve for a two-year term. William M. LeFevre, M.D., Muskegon, also a founder of MAP and its first president, will complete his term as president but will remain on the Board for another year as will John G. Manning, M.D., Saginaw and Luther R. Leader, M.D., Detroit.

Officers for 1961 were elected by the Board at its March meeting: John Nolen, D.D.S., Lansing, was elected president, Nathan B. Saulter, P.E., Detroit, vice president, Hollis Clark, Jr., DVM, Holland, treasurer and Elmer Mansm, A.I.A., Lansing, was re-elected secretary.

A Town Hall type meeting to consider the needs for an American Association of the Professions was held during the closing afternoon of the Congress. National leaders of the member professions participated in the discussions. Ernest B. Howard, M.D., assistant executive vice president of AMA, spoke for the medical profession. Further deliberations by national professional leaders on AAP will be held at a meeting scheduled for mid-summer.

Rename John N. Lord President Of Michigan Blue Cross

John N. Lord continues as president of Michigan Blue Cross re-elected recently for his fifth consecutive term. Mr. Lord is president of Lee & Cady and vice president of Grace Hospital in Detroit.

Elected vice president was John W. Paynter, who is vice president and treasurer of the J. L. Hudson Company. Ralph E. Phelps was re-elected treasurer, Wm. S. McNary was re-elected secretary and Hazel Kennedy re-elected assistant secretary. Mr. Phelps is assistant secretary of the S. S. Kresge Company.

O. O. Beck, M.D., of Birmingham, and James W. Logie, M.D., of Grand Rapids, were re-elected as medical representatives on the board of trustees.

Detroit Clinic Moves

The Social Hygiene Clinic of the Detroit Health Department has moved from its present quarters in Receiving Hospital to 8811 John C. Lodge, in building 7, Herman Kiefer Hospital. The telephone number is TRinity 2-7441, according to Benjamin Schwimmer, M.D., clinic director.

National Occupational Medicine Conference Held in Detroit

Two hundred members of the American Academy of Occupational Medicine met at the Detroit Statler Hotel February 8 for their annual three-day meeting. Chairman was Arthur J. Vorwald, M.D., chairman of the Industrial Medicine and Hygiene Department at Wayne State University College of Medicine.

On the scientific program committee were Duane Block, M.D., medical director, Rouge Division, Ford Motor Company; Edwin DeJongh, M.D., Pontiac Division, General Motors; William Jend, Jr., M.D., medical director, Michigan Bell Telephone Company; Seward Miller, M.D., professor of occupational medicine, University of Michigan; S. Dan Steiner, M.D., medical director, General Motors Corporation.

Editorial Comment:

The Lines Are Drawn Again

Despite the fact that Congress enacted a broad new program for health care of the needy and near-needy aged last year, President Kennedy and the Democratic leaders of Congress will push for a compulsory program tied to Social Security during the 1961 session.

Proponents of Forand-type legislation have tried to belittle the Kerr-Mills Bill as "inadequate" and a "stop-gap measure." Actually, the Kerr-Mills Bill will require hundreds of millions of dollars and will provide care for *all* persons over 65 who *need* help.

Before Georgia and the other states will hardly have had an opportunity to participate in this new program, the Democratic administration will be pushing for a national compulsory program to include all persons over 65 whether they need it or not. Decisions as to eligibility, benefits, fees, and all other matters will be made in Washington rather than at the state and local level as under the Kerr-Mills Bill.

All of these factors were made abundantly clear during the recent 14th Clinical Meeting of the American Medical Association in Washington, D. C. It was most appropriate that the meeting was held in Washington, for many of the statements by the officers of the Association and by the House of Delegates seemed directed as much to the new administration as to the physicians.

These statements reaffirmed medicine's opposition to social security medicine and urged all physicians to support state officials and provide leadership in implementing the Kerr-Mills Bill. The statements were clear and left no doubt as to where medicine stands.

As the 1961 session of Congress progresses, we wish to urge every physician in Georgia to keep himself, the members of his community, and his Congressman informed on this vital issue. The influence of one man may make the difference between the free practice of medicine and high standards on the one hand, and national compulsory health insurance and uniformly lower standards on the other.—*J.M.A. Georgia.*

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

May	23-25	Michigan Health Council State Conference	Ballenger Field House, Flint
June	4	Dedication of New MSMS Headquarters	Community College, Flint
June	16-17	Upper Peninsula Medical Society	East Lansing
June	19-21	University of Michigan Conference on Aging	Menominee
July	27-28	Coller-Penberthy Clinic	Ann Arbor
Sept.	27-28	Michigan State Medical Assistants Society	Park Place Hotel, Traverse City
Sept.	27-28	Woman's Auxiliary to MSMS	Pantland Hotel, Grand Rapids
Sept.	27-29	MSMS Annual Session	Pantland Hotel, Grand Rapids

"Teamwork," Theme For AMA Meeting

The American Medical Association's 110th annual meeting will attract an estimated 50,000 persons, including 25,000 physicians, into New York City, June 25-30. The convention will develop a theme of "Teamwork in Medicine."

The AMA meeting will open formally on Sunday, June 25, with a special preview luncheon and showing in the Coliseum for AMA officers and committee chairmen, members of the Board of Trustees, representatives of the Pharmaceutical Manufacturers' Association and invited guests.

Leonard W. Larson, M.D., 63-year-old pathologist from Bismarck, N. D., will be inaugurated as president of the AMA at 8:30 p.m., Tuesday, June 27 in the Waldorf-Astoria ballroom. Dr. Larson succeeds E. Vincent Askey, M.D., Los Angeles.

The AMA House of Delegates will meet at the Statler-Hilton, the headquarters hotel, at 10 a.m., Monday, June 26. The first order of business will be to select the recipient of the AMA Distinguished Service Award given annually to the physician who has made an outstanding contribution to medicine.

Matters to be considered by the House will, in all probability, include:

—A supplemental report relating to closer cooperation between the American Medical Association, the American Hospital Association, the National Association of Blue Shield Plans, and the Blue Cross Association in promoting "maximum development of the voluntary non-profit prepayment concept to provide health care for the American people."

—A report by the AMA Judicial Council, the "supreme court" of medicine, which will cover the controversial relationship between doctors of medicine and doctors of osteopathy.

—Group disability insurance for all members of the American Medical Association.

—A status report by the AMA Commission on the Cost of Medical Care, which is presently studying all facets of the broad medical care cost problem.

—A final report by a committee which studied all mechanisms for disciplining members of the medical profession.

—Washington legislation, especially various aspects of President Kennedy's program for health care of the aged through social security.

MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Operation Seat Belt

The Michigan Department of Health has been increasingly concerned about the fact that we have in this country a means of saving many lives and preventing many more severe injuries but do not make much use of it. We refer, of course, to seat belts. Surveys indicate that only about two per cent of the cars in this country are equipped with seat belts. Worse, only about one out of three of the people who have them, actually use them.

While seat belts are not quite in the same category as vaccines, there is a similarity in that both are capable of preventing disability and death. If only about two per cent of our people had purchased polio vaccine—and if two out of three of them carried it around in a vial—we would consider it a national disgrace. Yet this is precisely what is occurring with regard to seat belts.

We decided to make a tentative start toward improving this situation. We had from time to time sent out press releases and radio spot announcements promoting seat belts. We therefore decided to go ahead on our own and provide seat belts to our employees who were assigned a state car. These belts would be paid for out of our operating funds. We received requests for 68 belts to be installed in 38 cars. The only stipulation was that the belts must be requested in writing and that each person must agree to use them.

Having done this, we decided that we should see what could be done to make seat belts available to our own employees, inexpensively and at little inconvenience. It has always been a basic part of our philosophy that a public health measure must be not only effective but readily available and relatively inexpensive if it is to be widely accepted and used. Obviously, one of the problems with regard to seat belts is cost as well as inconvenience. We therefore checked with various local dealers until we got what we considered to be the best price possible—$6.72 per belt including tax and installation. These belts exceeded the recommendations of the Society of Automotive Engineers. Arrangements were then worked out so that employees could, if they wished, have their cars driven to the garage and the belts installed while they were at work. Thus, while the cost was still more than nominal, it was most reasonable, and the installation of the belts could be done at no inconvenience.

Once these things had been established, we began an educational campaign within the department, using our weekly news sheet as a medium of communication. A special fact-sheet on seat belts was prepared and distributed with the news sheet. A motion picture, *Safety Through Seat Belts*, which is in our film library, was shown to all those who wished to see it. This was done on company time and took about twenty minutes. Finally, samples of the various colors of belts were displayed in our lobby along with a register in which people could sign up for the number and color of belts desired.

At the end of the program, 243 seat belts were ordered by 102 people. Including our state cars then, 136 cars have been equipped with seat belts as a direct result of our program. As such, the program cannot be considered an overwhelming success. But it does represent about 25 per cent of our total employees—well above the 2 per cent average in the nation.

Another by-product of this seat belt program has been the recent announcement by Governor Swainson that seat belts will be installed in all state cars upon request of the persons to whom the cars are assigned. By the end of the year, according to Governor Swainson, all state cars will be so equipped.

The seat belt program was organized to achieve two goals. One, to demonstrate our own conviction of the importance of these belts so that we could more effectively urge that all state cars be equipped with them. This has already paid off. Second, we hoped to determine whether or not an extensive public education program would be of any real value. The answer to this is not so obvious. It is clear, however, that next year, when all automobile manufacturers plan to produce cars with seat belt fittings as standard equipment, public education on a continuing basis will be of some value.

Perhaps more significant is the realization that any business or industry can expect a considerable interest in, and acceptance of, seat belts if a program is conducted which will make them available at a reasonable cost and with little inconvenience. It is toward the promotion of such efforts that we feel we can be most effective at the moment.

We shall be glad to share with any local medical society any material used in our campaign.

Winslow Homer "THE HERRING NET" Art Institute of Chicago.

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SEARLE

HEART BEATS

(This material is provided by the Michigan Heart Association)

New MHA Officers

John D. Littig, M.D., Kalamazoo, is the new president of the Michigan Heart Association, elected at the annual meeting of members on "Michigan Heart Day" at the Statler-Hilton Hotel. Muir Clapper, M.D., Detroit, became president-elect, Lawrence Dooge, Grand Rapids, first vice-president and Mrs. James McEvoy, Detroit, second vice-president. Sidney E. Chapin, M.D., Dearborn, and W. C. Folley, Sc.D., Detroit, were re-elected as secretary and treasurer, respectively. New trustees are: Douglas Giles, Birmingham, Albert Heustis, M.D., Lansing, Mrs. Norris A. Host, Birmingham, Bernath P. Sherwood, Jr., Spring Lake, Robert Stow, M.D., Lansing, and Randall M. Whaley, Ph.D., Detroit.

JOHN D. LITTIG, M.D.

New Staff Member

Seymour Brieloff is the new director of Michigan Heart Association's Eastern Regional Office in Flint. Mr. Brieloff was formerly the director of operations for the Community Workshop of the Jewish Vocational Service in Detroit, where he had previously served as career counselor. Born in New York city, he obtained his Master of Education degree at the University of Miami, and brings 10 years of experience in the field of rehabilitation to the Heart Association.

Wet Clinics' Purpose and Procedures

The primary purpose of the Congenital and Rheumatic Heart Disease Wet Clinic is to teach diagnostic and therapeutic methods in congenital and rheumatic heart disease. The experience of the conducting physician, internist, pediatrician or cardiovascular surgeon, is drawn upon to aid the attending physicians in examining, evaluating and managing cardiac patients, and to better judge which patients may profit from angiocardiography and cardiac catheterization and other of the newer diagnostic tools in determining the feasibility of cardiac surgery.

A single wet clinic can probably best manage six to eight patients, with two to six participating doctors. Patients are selected from a wide range of cardiac disorders. Written histories and records of patients should be available, as well as x-rays, ECG's and laboratory studies for the attending physicians' information. Clinics are followed by a discussion period on the general problems involved.

The Michigan Heart Association will underwrite the payment of the honorarium and expenses of your consultant and therefore no charge will be made to the patients by the consultant.

For further information write: John G. Bielawski, M.D., Medical Director, Michigan Heart Association, 3919 John R, Detroit 1, Michigan.

Heart Disease Control

An institute on Heart Disease Control will be conducted by the University of Michigan School of Public Health from June 26 through July 1 in Ann Arbor. The Michigan Heart Association is one of the collaborating agencies in the program which includes lectures, seminars, discussion and demonstration from the aspects of Epidemiology, Prevention, Early Detection, Rehabilitation, Nutrition and Nursing related to Heart Disease.

Registration application must be sent not later than June 1 to: Director, Continued Education, School of Public Health, The University of Michigan, Ann Arbor, Michigan.

Association's Research Program, 1961-1962

The Michigan Heart Association Research Committee recommendations for 1961-62 approved by the Board of Trustees, have been allocated as follows:

1.	Dean's Fund	$ 60,000.00
2.	Medical Student Research Fellowships (25 at $600.00)	15,000.00
3.	Contingency Fund	15,000.00
4.	Grants-in-Aid	261,639.05
	TOTAL	$351,639.05

(Continued on Page 662)

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efficacious	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...."[1]
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palatable	Delicious ATARAX syrup pleases even the balkiest patient.

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References: 1. Freedman, A. M.: Pediat. Clin. North America *5*:573 (Aug.) 1958. 2. Nathan, L. A., and Andelman, M. B.: Illinois M. J. *112*:171 (Oct.) 1957. 3. Santos, I. M. H., and Unger, L.: Ann. Allergy *18*:179 (Feb.) 1960. 4. Litchfield, H. R.: New York J. Med. *60*:518 (Feb. 15) 1960.

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vitamin-mineral supplementation

Association's Research Program

(Continued from Page 660)

Grants-in-Aid were awarded to ten Michigan Medical institutions for research under the direction of responsible investigators as follows:

1. MARION I. BARNHART, PH.D., *Wayne State University*
   "Cellular Sites for Synthesis of Proteins Important in Blood Coagulation."
2. BERNARD BERCU, M.D., *Wayne County General Hospital*
   "Myocardial Blood Flow Using Radioactive Sodium."
3. RICHARD BING, M.D., *Wayne State University*
   "Myocardial Metabolism and Contractile Proteins of the Heart."
4. A. J. BOYLE, M.D., *Wayne State University*
   "Plasma Colloid Stability in Normal and Atherosclerotic Subjects."
5. GEO. O. CLIFFORD, M.D., *Wayne State University*
   "Mechanism of the Coagulation Abnormalities Induced by Hyperlipemia and Its Modification by Certain Agents."
6. VERNON N. DODSON, M.D., *University of Michigan*
   "Anti-heart Antibodies."
7. F. D. DODRILL, M.D., *Harper Hospital* (Cariovascular Surgery)
   "Synthetic Heart Valve."
8. F. E. GREIFENSTEIN, M.D., *Wayne State University*
   "The Use of the Buffer Amines for Reversing Respiratory Acidosis During Anesthesia and Surgery."
9. SIBLEY HOOBLER, M.D., *University of Michigan*
   "Arteriosclerosis and Hypertension."
10. THOMAS JAMES, M.D., *Henry Ford Hospital*
    "Morphologic Studies of the Human Heart with Clinical Correlation."
11. PRESCOTT JORDAN, JR., M.D., *Wayne State University*
    "Aortic Valvular Replacement."
12. JON J. KABARA, PH.D., *University of Detroit*
    "Simultaneous Use of Tritium and Carbon-14 Metabolites to Study the Dynamics of Lipid Metabolism."
13. CONRAD LAM, M.D., *Henry Ford Hospital* (Cardiovascular Surgery)
    "Experimental Cardiovascular Surgery."
14. B. M. LEWIS, M.D., *Wayne State University*
    "Pulmonary Capillary Bed in Cardio-Respiratory Disease."
15. PERRY MARTINEAU, M.D., *Herman Kiefer Hospital*
    "Blood Viscosity in Relation to Coronary Atherosclerosis."
16. JOHN S. MEYER, M.D. *Wayne State University*
    (A) "Clinical Evaluation of Combined Fibrinolysin and Anticoagulant Therapy in Cerebrovascular Disease."
    (B) "1—Pathogenesis of Vasospasm in Hypertensive Encephalopathy. 2—Cerebral Metabolism and Blood Flow in Vascular Disease."
17. N. J. MIZERES, M.D., *Wayne State University*
    "Neural Effect on the Coronary Blood Flow."
18. JOE MORRIS, M.D., *Wayne State University*
    "A Comparison Study of Valvuloplasty Techniques Using the Pulse Duplicator and Post Mortem Hearts."
19. E. E. MUIRHEAD, M.D., *Woman's Hospital*
    "The Influence of Renal Cells Grown in Tissue Culture on Experimental Hypertension."
20. A. C. NOLKE, M.D., *Children's Hospital*
    "Blood Pressure Determination in Small Infants."
21. JAN NYBOER, M.D., *Harper Hospital*
    "Evaluation of Ultra-Low Frequency Ballistocardiography and Electrical Impedance Plethysmography."
22. C. J. PARKER, JR., PH.D., *Wayne State University*
    "The Action of Anserine and Carnosine on the Mg-activated Myofibrilar Adenosine Triphosphatase Activity of Cardiac and Skeletal Muscle."
23. R. C. REYNOLDS, *University of Michigan*
    "A Study of the Effect of pH and Ionization on the Actions of the Sympathominetic Amines on the Vascular System of the Cat and Rabbitt."
24. H. J. ROBB, M.D., *Wayne State University*
    "Study of Microscopic Vascular Dynamics in Various Forms of Shock and Study of Vascular Changes Which Occur with Administration of Drugs Which Change the Caliber of Vessel and Affect Their Blood Flow."
25. P. A. RONDELL, PH.D., *University of Michigan*
    "Electrolyte Movements and Vascular Muscle Contraction."
26. J. N. SCHAEFFER, M.D., *Rehabilitation Institute*
    "Objective and Subjective Physical Disability Evaluation in Hemiplegia."
27. W. H. SEEGERS, PH.D., *Wayne State University*
    "Blood Coagulation: Purification of Inhibitors and Mechanisms of Their Action."
28. J. C. SISSON, M.D., *University of Michigan*
    "I^{131} Labeled Fat in Myocardial Infarct Patients."
29. HERBERT SLOAN, M.D., *University of Michigan*
    "Transplantation of the Heart."
30. AARON STERN, M.D., *University of Michigan*
    "The Development of an Intracavitary Combination Electrocardiographic and Phonocatheter Permitting Heat Sterilization. The Building of a Preamplifier for Intracavitary Phonocardiography."
31. D. E. SZILAGYI, M.D., *Henry Ford Hospital*
    "An Investigation of the Use of Vascular Substitutes in the Replacement of Arterial Segments."
32. D. E. VERNALL, PH.D., *University of Michigan*
    "The Teratogenic Effects of Trypan Blue on the Cardiovascular System of Mice."
33. J. M. WELLER, M.D., *University of Michigan*
    "Investigation of Abnormalities of Sodium and Potassium Metabolism in Hypertension."
34. P. WILLIS, III, M.D., *University of Michigan*
    "Investigation of the Mechanism of Blood Coagulation with Special Reference to Problems of Thromboembolic and Arterial Occlusive Disease."
35. A. J. ZWEIFLER, M.D., *University of Michigan*
    "Effect of Heparin on Experimental Thrombosis in Dogs."
36. W. S. WILSON, M.D., *University of Michigan*
    "1—Changing Intracardiac Conductivity and the EKG. 2—The Effect of Denervation of the Lung on Hypoxic Pulmonary Hypertension. 3—Changes in Sodium Excretion after Closure of Left to Right Shunts. 4—Preliminary Studies on the Denervated Heart."

AMA Sees Danger in Trampolines

Trampoline acrobatics performed by untrained amateurs can cause crippling and even fatal injuries, the American Medical Association said in a warning.

An editorial in the November 26 *AMA Journal* pointed out the dangers of increased popularity of trampoline tumbling among novices without proper supervision or instruction.

The most dangerous place on the trampoline is still the center of the mat, the *Journal* says.

you can't prescribe a more effective antibiotic than ERYTHROCIN®

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How much "spectrum" do you need in treating an infection? Clearly, you want an antibiotic that will show the greatest activity against the offending organism, *and the least activity against non-pathogenic gastro-intestinal flora.*

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And against many of the troublesome "staph" strains—a group which shows increasing resistance to penicillin and certain other antibiotics—Erythrocin continues to provide bactericidal activity. Yet, as potent as Erythrocin is, *it rarely has a disturbing effect on normal gastro-intestinal flora.* Comes in easy-to-swallow Filmtabs®, 100 and 250 mg.

Usual adult dose is 250 mg. every six hours. Children, in proportion to age and weight. Won't you try Erythrocin?

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ABBOTT

103204

Pathology Comment

These items are provided by the Michigan Pathological Society

Contraindications for Blood Transfusions

"Thoughtless prescription of blood transfusion is playing Russian Roulette with bottles of blood instead of a revolver. While the odds are in the physician's favor that nothing will go wrong, the patient takes the risk." This statement by Crosby† succinctly summarizes blood transfusion hazards.

Each year 3,000 persons die from an estimated 3.5 million blood transfusions; transfusions rank with appendicitis and anesthesia as causes of death. A legal opinion on blood transfusions has pointed out that a physician would be liable for damages following and caused by a transfusion that was not indicated by the facts of the case.

Even if no negligence could be proved, an action for damages would lie if the plaintiff could prove that a transfusion was not indicated medically. Fortunately this situation rarely presents itself in court, but the proper indications for transfusion deserve most careful consideration at all times. It is not a decision to be made lightly, and a surgical operation per se is not sufficient reason.

We must remember that we are treating the patient, not his laboratory reports or our own anxiety. Transfusions are neither tonics nor placeboes; they are not substitutes for careful medical or surgical therapy. It is far better to treat a simple iron deficiency anemia by iron replacement than by transfusions. As a single unit of blood only provides the patient with 1 to 1.5 gm. of hemoglobin per 100 ml. of blood, the use of a single unit transfusion is rarely justified in view of the hazards involved.

Before ordering the next transfusion, please consider the following risks:

1. Hepatitis
2. Reaction from incompatible blood
3. Allergic reactions
4. Sensitization of the patient
5. Possible bacterial contamination

Except for exchange transfusions there are two indications for blood transfusion:

1. Improvement of circulatory system stability by replacement of blood volume where the patient's life is imperiled.
2. Prevention of acute hypoxia or shock by improving the oxygen-carrying capacity of the blood.

These are the facts to consider. The decision is yours.

---

†Crosby, W. H.: *Blood*, 13:1198, 1958.

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comments: "In practically every instance... the patients experienced relief from dryness and pruritus."

STUDY 2 *Lubowe, I. I.: Western Med. 1:45, 1960.*

satisfactory results in 94% of cases

comments: Sardo "reduced inflammation, itching, irritation, and other discomfort..."

STUDY 3 *Weissberg, G.: Clin. Med. 7:1161, 1960.*

satisfactory results in 91% of cases

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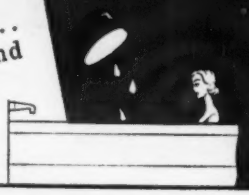

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AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine.

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LITERATURE AVAILABLE ON REQUEST

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*U.S. Patent Nos. 2,628,185 and 2,907,768

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Brief and to the Point

RECEIVES AWARD—Lynn A. Ferguson, M.D., Grand Rapids, recently received the third annual Aquinas College Award. The Rt. Rev. Msgr. Arthur F. Bukowski, Aquinas president, presented the bronze medallion at a special honors convocation at the school. It cited Dr. Ferguson's "pioneering achievement in the field of proctology and . . . his inestimable contribution to the civic and social welfare of Grand Rapids."

* * *

FETED BY COMMUNITY—Community leaders of Addison, in Southern Michigan, honored B. H. Growt, M.D., recently at a "Recognition Day." Dr. Growt, who will soon be 70 years, has practiced 40 years at Addison. He was especially cited for sparking the drive for the first Addison hospital in 1922.

* * *

HONORED BY LIONS—Four Mt. Pleasant doctors were honored at a recent meeting of the Lions Club there. Recognized for donating time and services to examine needy children were George L. Brown, M.D., F. D. Schall, M.D., W. E. Hersee, M.D., and S. L. Chamichian, M.D.

* * *

LEADERS CHOSEN—The Michigan Society of Neurology and Psychiatry Michigan District Branch of the American Psychiatric Association has elected Eugene J. Alexander, M.D., Detroit, as president. Alvin B. Rosenbloom, M.D., Detroit, will serve as chairman of the public relations committee, and Walworth R. Slenger, M.D., Kalamazoo, as editor of the Society newsletter.

* * *

CHOSEN—The new Veterans Administration Research Advisory Committee includes Charles G. Child, III, M.D., Ann Arbor. The committee represents a consolidation of three former groups which advised the VA on medical research at the national level regarding radiobiology, radioisotopes and aging.

* * *

OFFERS GRANTS—Grants will be made for a course of study leading to a graduate degree in public health by the Michigan Tuberculosis Association, 403 Seymour Avenue, Lansing 14. The amount of the grant will be $3,500 plus $500 for each dependent as defined for income tax purposes, the total not to exceed $5,000. For further information and application forms write to the Michigan Tuberculosis Association.

AIDS N. H. SCHOOL—A W. K. Kellogg Foundation grant of $500,000 will enable Dartmouth College, Hanover, New Hampshire, to add a teaching auditorium adjacent to the recently constructed main building for its School of the Basic Medical Sciences. The amphitheater-type auditorium, equipped with audio-visual teaching facilities, will have a seating capacity of 400.

* * *

CO-AUTHOR—George L. Waldbott, M.D., Detroit, is co-author of a book entitled "Tratado de Allergia," an extensive monograph on the treatment of allergic diseases published in Barcelona, Spain, by Dr. F. Arasa, Edit. Cientifico Medica, 1960. The chapters on Bronchial Asthma and Contact Dermatitis were assigned to Dr. Waldbott.

* * *

AMA INVITES PAPERS—The Council on Scientific Assembly invites physicians to submit titles and brief abstracts of scientific papers they wish to deliver at the 1962 annual meeting of the American Medical Association, which will be held in Chicago, June 11-15. The deadline is October 15.

The AMA meeting in 1962 will be held in Chicago's new $35,000,000 exposition center on Lake Michigan, which has 300,000 square feet of exhibit space alone.

* * *

SUPPORTS RESEARCH—The American Cancer Society's Southeastern Michigan Division made a $50,531 grant in support of a lung cancer research project headed by Arthur Vorwald, M.D., Detroit. The grant will support Dr.

(Continued on Page 672)

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Vorwald's study of pulmonary cancer induced by compounds of beryllium and other test agents in experimental animals. Dr. Vorwald is interested in the fate of beryllium once it enters the bronchi of the test animals and also what happens on the biochemical level after the compound penetrates the cells.

* * *

AMA STAFF NEWS—James Reed, editor of The AMA News, has taken over the added position of director of Press Relations of the American Medical Association, succeeding John L. Bach. Mr. Bach now is the assistant director of the Department of Scientific Assembly, a newly-created post. Kenneth David, formerly with United Press, and St. Louis, Topeka, Kan., and Portland, Ore., newspapers, has joined The AMA News staff as executive editor.

* * *

RETIRES AT WSU—Marjorie J. Darrach, director of the Medical Library Service at Wayne State University for 37 years, retired April 1. Miss Darrach, 70, a native of Toronto, Ont., came to Detroit in 1918 as library assistant for the Detroit Public Library and she was appointed in 1924 as chief of the medical science department. Her successor is Vern Pings, M.D.

* * *

ARTICLE ABSTRACTED—PHARMAQUICK, published by Ames Company, Inc., of Elkhart, Indiana, has abstracted the article "Phenylketonuria In Young Infants" by Richard Allen, M.D., George Lowrey, M.D., and James Wilson, M.D., of Ann Arbor, which originally appeared in the December 1960 number of the Journal of the Michigan State Medical Society.

* * *

WORKSHOP PLANNED—A "Workshop on Rehabilitation of the Disabled Homemaker" will be held July 2-8, at Michigan State University to give training to professional persons who have the responsibility of working with disabled homemakers or establishing or supervising programs that in some way involve the rehabilitation of the disabled homemaker.

The workshop, financed by the Michigan Heart Association, is sponsored by the MSU College of Home Economics, with the co-operation of the Rehabilitation Institute of Detroit and the Rehabilitation Committee of the American Heart Association.

* * *

RECEIVES PLAQUE—The Midland Community Center presented a plaque to E. O. Barstow, M.D., Center board director, for devoted service. The appreciation plaque, in part, stated that "His leadership and spirit have been an inspiration to the entire community." Herbert H. Dow made the presentation.

* * *

U M CLASS OF 1965—The University of Michigan Medical School has selected 190 students to enter medical training in September as the Class of 1965. An additional 22 students have been chosen as alternates to fill any vacancies created by drop-outs, and to bring the total entering class to 200.

MILTON DARLING LECTURESHIP—The third annual lecture was held on "Residents' Day" at Wayne State University, March 22. Duncan E. Reid, M.D., Harvard University, was the chief speaker. Other guest speakers included C. Paul Hodgkinson, M.D., Detroit, president of the American College of Obstetricians and Gynecologists; and Harold C. Mack, M.D., also of Detroit.

* * *

WAYNE SYMPOSIUM—A two-day continuing education symposium on Rheumatology and Metabolism sponsored by Wayne State University College of Medicine was held recently. Speakers were Drs. Richard J. Bing, M. K. Keech, Newton Rottenberg, J. J. Lightbody, Herbert Rosenbaum, Alfred Klein, Joseph Hess, Joseph Shaeffer, Carl Sultzman, Charles R. Harmison, Robert B. Leach, Fred Whitehouse, Herschel Sandberg, Robert Thompson, Ivan J. Mader, Yoshikazu Morita and Richmond Smith.

* * *

FELLOWSHIPS WINNER—Bruce A. Kyburz, of Lansing, a junior at Wayne State University College of Medicine, has been awarded a $1,503 grant to spend 12 weeks at Christ Hospital, Kapit, Sarawak, Borneo. Bruce was one of 30 medical students who received foreign fellowship grants from Smith, Kline and French Laboratories, Philadelphia.

* * *

COURSES OFFERED—The University of Illinois College of Medicine Department of Otolaryngology will offer an intensive postgraduate basic and clinical program, September 23-30, and also a postgraduate course in Laryngology and Bronchoesophagology from October 23 through November 4.

* * *

REMOTELY CONTROLLED CATHETER—A remotely controlled catheter that can be directed into the human heart's cavities and passageways was developed by GM Research Special Problems department in conjunction with Richard J. Bing, M.D., Detroit. The catheter already has been used on humans and Dr. Bing has indicated it may become an important diagnostic instrument in heart disease. Although precision built, indications are it can be manufactured at reasonable cost for routine use in heart studies and diagnosis.

* * *

HONORED—George D. Zuidema, M.D., Ann Arbor, is one of 25 young medical scientists to be appointed Markle Scholars in Medical Science by the John and Mary R. Markle Foundation of New York. The Markle program seeks to help relieve the faculty shortage in medical schools by giving young teachers financial assistance. Each school receives $30,000, at the rate of $6,000 a year for the next five years, toward support of the scholar and his research.

* * *

COLORED FILMS AVAILABLE—A series of 16-mm color and sound motion pictures about various aspects of physical diagnosis is available for rental or purchase from Wayne State University College of Medicine. The project was sponsored by CIBA Pharmaceutical Products, Inc., Sum-

mit, N. J., but none of the company's products are mentioned.

The February 4, 1961 issue of the *Journal of the American Medical Association* reviewed the films in an editorial and pointed out the "extremely useful function" of the series. It also complimented CIBA's "record of promotion of medical education programs."

All requests for showing or purchase should be directed to the Audio-Visual Utilization Center, Wayne State University, Detroit 2.

* * *

FILM OFFERED—A new tuberculin testing film, "Rancher Glen's Secrets," is now available to Michigan schools through the Michigan Tuberculosis Association and its local affiliates. This ten-minute color film features Rancher Glen, MTA's singing cowboy, and can be used to explain tuberculin testing to children in the elementary grades. The movie was produced co-operatively by Wayne State University, the Wayne County Tuberculosis and Health Society, and the Michigan Tuberculosis Association. The film is free of charge, as a Christmas Seal service. Mail requests to: Michigan Tuberculosis Association, 403 Seymour Avenue, Lansing 14.

* * *

MEDICAL MEETINGS, USA

Western Conference on Anesthesiology, Biennial, May 16-18, 1961, Sheraton Hotel, Portland, Oregon.

American College of Cardiology, Inc., May 16-20, 1961, Biltmore Hotel, New York, N. Y. Philip Reichert, M.D., 350 Fifth Ave., Empire State Bldg., New York 1, Executive Director.

(Continued on Page 676)

(Continued from Page 674)

American Association of Plastic Surgeons, May 17-19, 1961, Commodore Hotel, New York City. Thomas D. Cronin, M.D., 6615 Travis St., Houston 25, Texas, Executive Secretary.

American Association for the History of Medicine, May 18-20, 1961, Shoreland Hotel, Chicago. John B. Blake, c/o Smithsonian Institution, Washington 25, D. C., Secretary-Treasurer.

American Laryngological Association, May 21-22, 1961, Lake Placid Club, Lake Placid, N. Y. Lyman G. Richards, M.D., 12 Clovelly Rd., Wellesley 81, Mass., Executive Secretary.

American Thoracic Society, May 22-25, 1961, Netherland-Hilton, Cincinnati. Frank W. Webster, 1790 Broadway, New York 19, Executive Secretary.

Minnesota State Medical Association, 108th Annual, May 22-24, 1961, St. Paul Municipal Auditorium. 496 Lowry Medical Arts Bldg., St. Paul.

American Orthopaedic Association, May 22-25, 1961, The Ahwahnee, Yosemite, Calif. Lee Ramsey Straub, M.D., 535 E. 70th St., New York 21, Secretary.

American Urological Association, May 22-25, 1961, Biltmore Hotel, Los Angeles, William P. Didusch, 1120 N. Charles St., Baltimore 1, Executive Secretary.

National Tuberculosis Association, May 22-25, 1961, Netherland-Hilton, Cincinnati, James G. Stone, 1790 Broadway, New York 19, Executive Secretary.

(Continued on Page 678)

(Continued from Page 676)

American Laryngological, Rhinological and Otological Society, Inc., May 23-25, 1961, Lake Placid Club, Lake Placid, Essex Co., N. Y. C. Stewart Nash, M.D., 708 Medical Arts Bldg., Rochester 7, N. Y., Secretary.

American Gastroscopic Society, May 24, 1961, Drake Hotel, Chicago. Arthur M. Olsen, M.D., Mayo Clinic, Rochester, Minn., Secretary.

American Gastroenterological Association, May 25-27, 1961, Drake Hotel, Chicago. Wade Volwiler, M.D., Dept. of Med., Univ. of Washington, Seattle 5, Secretary.

American Otological Society, Inc., May 26-27, 1961, Lake Placid Club, Essex County, N. Y. James A. Moore, M.D., 525 E. 68th St., New York 21, Secretary-Treasurer.

Trudeau School of Tuberculosis and Other Pulmonary Diseases, Forty-sixth Session, June 5-23, 1961, Saranac Lake, N. Y. For information write to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 670, Saranac Lake, N. Y.

American Electroencephalographic Society, June 8-11, 1961, Hotel Claridge, Atlantic City, N. J. George A. Ulett, M.D., Malcolm Bliss Mental Health Center, 1420 Grattan, St. Louis 4, Executive Secretary.

American Neurological Association, June 12-14, 1961, Hotel Claridge, Atlantic City. Melvin D. Yahr, M.D., Neurological Institute, 710 W. 168th St., New York 32, Executive Secretary.

Society of Nuclear Medicine, June 14-17, 1961, Penn Sheraton Hotel, Pittsburgh. Samuel N. Turiel, 430 N. Michigan Ave., Chicago 11, Executive Administrator.

American Dermatological Association, June 16-20, 1961, Castle Harbour Hotel, Tucker's Town, Bermuda. Wiley M. Sams, M.D., 25 S.E. Second Ave., Miami 32, Fla., Secretary.

American Proctologic Society, June 21-24, 1961, Pittsburgh Hilton Hotel, Pittsburgh. Norman D. Nigro, M.D., 10 Peterboro St., Detroit, Secretary.

American Geriatrics Society, June 22-23, 1961, New York City. Richard J. Kraemer, M.D., 2907 Post Rd., Greenwood, Warwich, R. I.

American Rheumatism Association, June 22-23, 1961, Hotel Roosevelt, New York City. Gerald W. Speyer, 10 Columbus Circle, New York 19, Executive Secretary.

Endocrine Society, June 22-24, 1961, Hotel Biltmore, New York, N. Y. Henry H. Turner, M.D., 1200 North Walker, Oklahoma City 3, Secretary.

American Therapeutic Society, June 22-25, 1961, Essex House, New York City. Oscar B. Hunter, Jr., M.D., 915-19th St., N.W., Washington 6, D. C., Secretary.

American College of Chest Physicians, June 22-26, 1961, Hotel Commodore, New York City. Murray Kornfeld, 112 E. Chestnut St., Chicago, Executive Director.

American College of Angiology, June 23-25, 1961, Savoy-Hilton Hotel, New York City. Alfred Halpern, Ph.D., 11 Hampton Court, Great Neck, N. Y., Secretary.

American Academy of Tuberculosis Physicians, June 24, 1961, Henry Hudson Hotel, New York City. George P. Bailey, M.D., P.O. Box 7011, Denver 6, Colorado, Secretary.

American Diabetes Association, Inc., June 24-25, 1961, Commodore Hotel, New York City. J. Richard Connelly, 1 E. 45th St., New York 17, Executive Director.

(Continued on Page 680)

(Continued from Page 678)

Association for Colon Surgery, June 25, 1961, Barbizon-Plaza Hotel, New York, N. Y. Robert Turell, M.D., 25 East 83rd St., New York 28, Secretary-Treasurer.

Society for Vascular Surgery, June 25, 1961, Biltmore Hotel, New York City. George H. Yeager, M.D., 314 Medical Arts Bldg., Baltimore 1, Secretary.

American Medical Association, Annual Meeting, June 25-30, 1961, New York City. F. J. L. Blasingame, M.D., 535 N. Dearborn, Chicago 10, Executive Vice-President.

American Physicians Art Association, June 26-30, 1961, New York City. Alfred A. Richman, M.D., 307 Second Ave., New York 3, Executive Secretary.

Society for Investigative Dermatology, June 27-29, 1961, Barbizon-Plaza Hotel, New York City. Herman Beerman, M.D., 255 S. 17th St., Philadelphia 3, Secretary-Treasurer.

American Society of Facial Plastic Surgery, June 28, 1961, Hotel Elysee, New York. Samuel M. Bloom, M.D., 123 E. 83rd St., New York 28, Secretary.

American Physical Therapy Association, July 2-7, 1961, Palmer House, Chicago. Lucy Blair, 1790 Broadway, New York 19, Executive Director.

Michigan Authors

Joseph W. Hess, M.D., Detroit, "Lead Encephalopathy Simulating Subdural Hematoma in an Adult," *The New England Journal of Medicine*, February 23, 1961.

Paul U. Fechner, M.D., and **Ina Fechner, M.D.,** Ann Arbor and Eloise, "Influence of Pyrogen on Healing of Corneal Ulcers," *Archives of Ophthalmology*, March, 1961.

John A. Meyer, M.D., David A. Blumenstock, M.D., and **Frederick B. Berry, M.D.,** Ann Arbor, "Procainamide Hydrochloride in Ventricular Defibrillation," *Archives of Surgery*, March, 1961.

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IN MEMORIAM

FRANK O'BRIEN CONNOLLY, M.D., fifty-nine, Pleasant Ridge physician, died February 26, 1961.

Born in Austria, Doctor Connolly came to the Detroit area forty-five years ago. He was graduated from the University of Detroit, and Wayne State University College of Medicine. He served his internship at Providence Hospital, Detroit, and was on the staff of Mt. Carmel Mercy Hospital, Detroit.

Doctor Connolly was a fellow of the American College of Surgeons, and an active member of the Michigan State Medical Society.

RICHARD M. McKEAN, M.D., sixty-five, Detroit physician for forty years, died March 20, 1961.

A nationally known specialist in internal medicine, he was a 1919 graduate of the University of Michigan medical school. He served in World War II as a colonel with the 36th General Hospital in the Mediterranean and European theaters and was awarded the Legion of Merit.

R. M. McKEAN

He was a professor at Wayne State University College of Medicine. Professional affiliations included the American College of Physicians and the Royal Society of Medicine, and he was past president of both the Detroit Academy of Medicine and the Detroit Medical Club. For years, he served as a member of the progressive Postgraduate Medical Education Committee of MSMS.

Doctor McKean was a member of the Detroit Club, University Club and was a past member of the board of governors of the U. of M. Club. He was a director of the Detroit Citizens League.

HAZEL RUTH PRENTICE, M.D., sixty-two, Kalamazoo pathologist since 1929, died March 18, 1961.

Doctor Prentice served as pathologist and director of the laboratory at Bronson Hospital for nearly thirty years, until her retirement in 1958. She came to Kalamazoo in 1929, after receiving her medical degree at the University of Michigan and interning in Philadelphia.

Born in Worcester, Massachusetts, she graduated from Smith College in 1919.

She was a past president of the Michigan Pathological Society, past president of the Kalamazoo Women's Business and Professional Women's Club, and a member of Phi Beta Kappa.

DELMA F. THOMAS, M.D., seventy-two, Detroit physician for nearly forty years, died March 20, 1961.

Doctor Thomas came to Detroit in 1913, three years after graduating from the University of Denver. She graduated from Wayne State University College of Medicine in 1922.

Doctor Thomas was a life member of the Michigan State Medical Society, a member of the Professional Women's Club, and long acted as house doctor for coeds at the University of Detroit.

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